L-Università ta' Malta
Faculty for Social Wellbeing

Examining the Experience of First-Contact Professionals in Dealing with and Diagnosing Eating Disorders

Research Commissioned by: Fondazzjoni Kenn għal Saħħtek

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Published at Poulton's Ltd - Printers-Offset, Zejtun - Malta

The research team would like to thank Ms Jamie Bonnici, RSO II, for her invaluable contribution with statistical analysis.

Eating disorders are no joke

This is another study we were commissioned to do with Dar Kenn ghal Sahhtek. This organisation is at the heart of services being provided to alleviate the pain that such a condition brings about, but not only. Together with the Faculty for Social Wellbeing it is providing evidence-based data to help society and policy makers try to address the nuances that hover around this complex issue. This study, we hope, will provide us with another loop in terms of data and recommendations on how to deal with diagnosing eating disorders and the role of professionals in this very complex issue. I thank the whole team who worked on this project. I must say it has been so enriching and positive to work with such a committed group of professionals at Dar Kenn ghal Sahhtek. More collaboration beckons.

Prof. Andrew Azzopardi
Dean

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Executive Summary

BACKGROUND

Typically eating disorders (EDs) emerge in childhood or early adolescence, however they can develop at any age. Research shows that it is vital for persons with emergent eating disorders to be diagnosed as early as possible, as early treatment leads to an improved prognosis and outcome (Worsfold & Sheffield, 2019; Zhang & Wing, 2015). Yet, despite the fact that persons with emerging eating disorders come into contact with various professionals, diagnosis levels remain low. Improved ED recognition and diagnosis could save sufferers years of distress and harmful habits. Professionals such as educators, doctors, psychologists, dentists, gastroenterologists, counsellors and others are excellently placed to recognise a potential eating disorder and could contribute significantly to earlier diagnosis and subsequently treatment. However, there are several barriers to ED recognition, such as inadequate professional knowledge of EDs, patient evasiveness, cultural differences between practitioner and patients and the fact that ED symptoms could also be associated with other conditions, making them harder to identify.

This study investigated the state of professionals' knowledge of and sought to understand whether they feel empowered to take the necessary actions to assist potential sufferers.

Project Purpose and Design:
The research questions guiding this study were:

(i) What is the state of knowledge of eating disorders of professionals who may be first-point-of-contact for potential sufferers?

(ii) How confident do first-contact professionals feel in talking to persons they suspect may have an eating disorder?

(iii) How can the health sector and Dar Kenn għal Saħħtek respond to these challenges?

This study was granted ethical approval on 20 May 2021 and is in conformity with the University of Malta's Research Code of Practice and Research Ethics Review Procedures. The primary data for this study was collected via questionnaire and focus groups. A questionnaire, entitled ED Knowledge Among Professionals Questionnaire was created for the purposes of this research study, based on the literature and previous studies. It was distributed through the professional associations to a number of pratitioners, including psychologists, teachers, doctors, social workers, nutritionists and other service providers. In all the questionnaire was sent to 24 professional associations and 5 private entities, and a total of 123 valid replies were received. Qualitative data, to examine the research questions in further depth, was assembled from 15 participants across four focus groups. These were held with groupings of different professionals: Medical professionals, Sports and Food professionals, Mental Health professionals, and Education and Caring Professionals.

Notwithstanding the strengths of this study, such as the use of targeted purposive sampling of persons from professions that could bring them into contact with potential eating disorder sufferers, the study is not without limitations. Despite targeted purposive sampling, some professions were highly responsive, while other fields of practice were under-represented, such as the Nursing profession, from whom no replies were received. However, gaps perceived in questionnaire responses were compensated for in the focus group recruitment of participants.

Additionally, questionnaire respondents were overwhelmingly female, although factors such as interest in the subject should also be taken into consideration (Smith, 2008).

RESULTS

The eating disorder knowledge items of the questionnaire were tested for internal reliability using the Cronbach's Alpha test, returning a result of 0.85, denoting good internal consistency (Price et al, 2017). The questionnaire showed that overall knowledge of eating disorders among professionals is good, although there is some discrepancy within as well as between professions regarding the extent of knowledge for the specific eating disorders. ARFID (Avoidant/Restrictive Feeding Disorder), emerged as the least know ED. The questionnaire also revealed that the mental health professionals have statistically significantly better knowledge of eating disorders than educators, possibly due to mental health literacy being integral to the mental health professions but not to education professions. Across the board, professional practitioners have good ED knowledge and do experience eating disorders. Most professionals follow up with the person, however this is not automatic and should probably become widespread practice. It was established that most professionals would find it difficult to approach a potential eating disorder sufferers, as they do not feel that they have adequate knowledge and training, and indeed expressed a desire for more instruction in the subject.

Like the questionnaire, the qualitative data revealed almost all Focus Group participants, across a number of fields of practice, have had encounters with eating disorders. The extent of this could indicate that these disorders are more widespread than is offically acknowledged. Thematic analysis of the qualitative data revealed four overarching themes: Professionals' Experiences with EDs, Failures in Systems and Training, Family, Friends and Significant Others, and Education. The study also examined professionals' learning needs.

Professionals' Experiences with EDs – Despite most professionals confirming that they have had encounters with ED sufferers, most do not feel competent enough to step in and identify that the symptoms exhibited may belong to an eating disorder, or to assist the person. Participants stated that they do not feel confident in their knowledge, and revealed that their formative training contained very little specific instruction about eating disorders. The knowledge they had was acquired through their own research and self-study. With access to information, knowledge and especially training about how to approach these situations, it is highly likely that professionals from all fields will realise that they have a part to play in assisting persons with emergent eating disorders, and will feel confident enough to step up to the role.

Failures in Systems and Training – Besides a lack of training at formative level, and a dearth of continuing professional development (CPD) courses that deal with eating disorders, current systems tend to view EDs as conditions that can only be tackled by professionals from the ED field. As well as asking for a more holistic approach, participants mentioned that they would like to have more inter-profession collaboration. Participants also expressed disappointment in practices that maintain unhealthy habits within the family as well as culturally, calling for a cultural shift that will give prominence to healthy eating habits, the serving of healthy foods and sensible portions in restaurants, and a sports-mindset that are currently lacking in our country.

Family, Friends and Significant Others – Family, friends and significant others are a crucial element in the lives of ED sufferers. A supportive family is a crucial element of ED recovery, encouraging sufferers to go to treatment and supporting them along the way. However, family or friends that are not supportive or that encourage dysfunctional or flawed habits, such as food restraint, over indulgence or excessive exercise, could be a liability. Family is the environment where the foundations for life habits are laid should be considered in any drive for cultural change or ED awareness campaign.

Education – Educational establishments are centres of learning and influence and along with family, constitute an environment where children and young people spend much of their time. Teachers and other education professionals who spend so much time with their charges are in an excellent position to spot changes in their pupils. Children open up to teachers and this places them in an excellent position to identify if the person is going through a crisis or might have an eating disorder. School environments are very influential also in the transmission of knowledge and values, and the formation of good habits. Schools and educators should not be overlooked as valuable collaborators.

Training Needs – This research study also examined the education and information needs of professional practitioners in Malta. It was found that the vast majority of study participants would value receiving further instruction and information about eating disorders, especially in the form of CPD courses, as currently there are no such courses being offered. Participants expressed a preference for online courses, although a hybrid format that would allow for some physical interaction would also be welcome.

This study has shown that there is a need as well as a request from professionals from various fields to learn more about eating disorders. While certain professions, such as doctors or psychiatrists, are typically seen as being better placed to diagnose EDs, the data explored in this study confirms that any professional that comes into contact with clients, students or patients, can help potential sufferers. It is hoped that this will help to cut short the time sufferers spend living with an eating disorder and ensure a better outcome for the person.

RECOMMENDATIONS

The above findings gave rise to a number of recommendations for practice and policy, and research; and will enable Dar Kenn għal Saħħtek to plan future interventions.

Policy recommendations include providing training courses targeted at various professional groups, as well as CPD courses and holding discussions with providers of formative training courses to include more contend on eating disorders, as well as assisting schools and educators in recognising EDs and collaborating with stakeholders to bring about a cultural change to reduce the impact of effects such as detrimental restaurant practices and lack of sporting culture.

Further research could take the shape of research into best practices for ED prevention programmes, undertaking a study to examine ARFID in the population, as well as investigating the causes and epidemiology of obesity in Malta.

CONCLUSION

It is hoped that this study will help raise awareness of the level of eating disorder knowledge of professionals in Malta and assist in the provision or further training and instruction, so as to enlist the help of practitioners in identifying and tacking eating disorders and improving the outlook for sufferers.

Chapter 1
Introduction and a Review of the Literature

1.INTRODUCTION

Eating disorders typically emerge in childhood or early adolescence, although they can develop at any age. Jenkins (2005) states that, out of the 5 million Americans suffering from an eating disorder at the time of her study, 85% were adolescents. Adolescence is associated with high risk for the development of an eating disorder (Treasure et al., 2010). Research shows that it is vital for persons with emergent eating disorders to be diagnosed as early as possible, given that the prognosis and outcome are better the earlier the disorder is recognised and treated (van Son et al., 2010; Worsfold & Sheffield, 2019; Zhang & Wing, 2015). Yet, despite the fact that persons with emerging eating disorders come into contact with various professionals, diagnosis levels remain low. This could be because eating disorders are hard to spot, mainly as sufferers tend to be secretive or in denial, and tend to lie about their condition (Jenkins, 2005). Nonetheless, improved ED recognition and diagnosis could save sufferers years of distress and harmful habits.

Professionals such as educators, doctors, psychologists, dentists, gastroenterologists, counsellors and others are excellently placed to recognise whether a person presents with indications that could signal the presence of an Eating Disorder. This study will investigate the current state of knowledge of these professionals, examine any gaps in their knowledge and seek to understand whether they feel that they are able to recognise EDs in young people and feel empowered to take the necessary actions to assist them. speak to them.

1.2. LITERATURE REVIEW

1.2.1. Eating Disorders

The American Psychiatric Association (APA) describes eating disorders as "serious behavioral conditions characterized by severe and persistent disturbance in eating behaviors and associated distressing thoughts and emotions. They can be very serious conditions affecting physical, psychological and social function." (APA, 2021, para. 1). The latest edition of the Diagnostic and Statistical Manual of Mental Health Disorders, known as the DSM-5 (APA, 2013), lists Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder as the most well-known and prevalent eating disorders. Another eating disorder, also listed in the DSM-5, that is becoming more frequently diagnosed is Avoidant/Restrictive Feeding Disorder (ARFID), previously known as Selective Eating Disorder in earlier versions of the DSM (APA, 2013).

1.2.2. The Main Eating Disorders

Anorexia Nervosa (AN) is characterised by an extreme fear of gaining weight, abnormally low body weight and distorted perception of weight, triggering a strong wish to control weight and body shape, with sufferers utilising extreme efforts, including starvation, to achieve this objective (Treasure et al., 2010). The pursuit of the anorexic ideal has significant health and psychological consequences for sufferers, yet they remain always discontented (Orsini, 2017). No matter how much weight is lost, sufferers remain ever fearful of weight gain and constantly desire to lose more weight. This is because anorexia is not about weight or food, but rather, it is a dangerous and unhealthy psychological way to exert control over emotional or psychological issues (Williamson, 1990). Despite being the rarest of the eating disorders, anorexia has the highest mortality risk of all the eating disorders and the lowest recovery outcomes (Arcelus et al., 2011).

Bulimia Nervosa (BN) is typified by frequent and uncontrollable episodes of overeating, or binges, wherein sufferers typically consume thousands of calories in a single sitting which are offset by extreme efforts to avoid gaining weight, such as purging, fasting, the ingestion of laxatives or diuretics, or extreme exercise (Treasure et al., 2010). These behaviours set up a vicious cycle that wreaks havoc on body and mind, and tend to be accompanied by feelings of shame and extreme secrecy (Orbanic, 2001).

Binge Eating Disorder (BED), is another eating disorder that is becoming increasingly well-known and prevalent. BED was added as a separate eating disorder to the DSM-5 in 2013 and consists of compulsive eating without purging behaviours, however it is not be confused with overeating (Amianto et al., 2015). It is characterised by recurring, uncontrollable episodes of excessive food consumption over a short period of time, often to the point of discomfort (Treasure et al., 2010). As a result, sufferers are highly likely to be overweight or obese, and experience feelings of shame and guilt (Craven & Fekete, 2019). Typically binge eaters are dissatisfied with their body shape, but this is not accompanied by body image distortion as with anorexia or bulimia (Amianto et al., 2015).

Avoidant/Restrictive Food Intake Disorder (ARFID), also a newly designated condition under the DSM-5, is a type of extreme picky eating or food phobia that is characterised by a restriction or avoidance of certain foods that sufferers find themselves unable to eat - to the extent that they cannot meet their nutritional needs through food intake alone (Kohn, 2015). Often whole food groups will be excluded, such as meat or green vegetables, which, besides causing clinical nutritional deficiencies to persons suffering from this condition, also interferes significantly with their life (Zimmerman & Fisher, 2017).

1.2.3. Effects and Consequences of Eating Disorders

Eating disorders put the body under great strain. Persons with eating disorders experience a number of adverse medical and psychological problems. EDs have various physical effects, they disrupt natural growth, have detrimental effects on the circulation and nervous system, can cause cardiac and renal difficulties and chronic pain (Nagl et al. 2016). “The medical impact of eating disorders is widespread, touching every organ system in the body” (Jahraus, 2018, p. 463). Although some of these effects can be reversed once detrimental feeding behaviours are stopped, some health consequences can be lasting, furthermore negative outcomes are even more severe for children and adolescents (Galmiche et al., 2019; Treasure et al., 2010). As well as impacting health, eating disorders also cause significant disturbance to an individual’s social and psychological wellbeing (Treasure et al., 2010). Eating disorders, particularly Anorexia and Bulimia, have the highest mortality rate of all the psychological illnesses and suicide attempts are common among patients with EDs, especially sufferers of Anorexia (Zhang & Wing, 2015).

Eating disorders arise for complex reasons and usually centre around a desire to control food intake, whereby, what starts as an attempt to eat healthily or lose weight, can spiral out of control (Morris, 2008). There is not usually a single cause for an eating disorder, nor is there agreement among experts as to what causes EDs (Stice & Desjardins, 2018). As well as attempts to diet, family dynamics and genetic factors are shown to have significant influence on the predisposition to eating disorders (Mitchison & Hay, 2014). A family history of eating or mental health disorders, as well as exceedingly high family expectations,

particularly in the case of female sufferers, are indicated as possible causes (Le Grange et. al., 2010). Psychological and emotional factors such as anxiety, depression, stress and low self-esteem, as well as abuse and childhood trauma, can also trigger an eating disorder (Rothschild-Yakar et al., 2018). Other factors thought to be significant risk stimuli for eating disorders are self-esteem and body dissatisfaction issues linked to the highly impossible ideals of beauty that are widespread online and on traditional media, for males as well as females (Tiggemann & Polivy, 2010).

Eating disorders cost sufferers dearly, in all spheres of their lives. Van Hoeken & Hoek (2020) state that over 3.3 million healthy life years are lost annually to eating disorders, mortality risk remains high, quality of life and earning potential of sufferers are reduced, and costs to national health systems are around 48% higher than for non-sufferers. Schmidt et al., (2016) found that the average course of an eating disorder is of around 6 years, while Treasure et al. (2015) state that in individuals with a duration of illness of more than 10-15 years, the course of the eating disorder is likely to have become chronic. These disorders exert a detrimental impact on every area of a person's life in terms of education, employment productivity and future security. Yet, despite high health service usage by ED sufferers, only a small percentage receive an early diagnosis (Worsfold & Sheffield, 2019). Recognising symptoms and diagnosing an eating disorder is no easy task. Sufferers often have comorbidities that cloud the issue, and often this is further complicated by the fact that sufferers tend to be secretive or in denial, with the result that symptoms remain hidden and are difficult to recognise.

1.2.4.Professional Awareness of Eating Disorders

Eating disorders are certainly prevalent in the population and professionals from various fields are well placed to recognise the symptoms and make onward referrals for sufferers or persons who are developing eating disorders or disordered eating. However, in reality this is a difficult task (Esposito, 2008; Waller et al., 2014). "Many patients with EDs are ashamed, do not think that they have a problem or do not want anyone interfering" (Waller et al., 2014, p. 148). Moreover, as Waller et al. add, once the patient's symptoms are identified as indicative of an ED, there is additional difficulty in getting the patient to treatment. Other factors that may stop sufferers from seeking help for their eating disorder or even from admitting that they have a disorder are fear of stigma and not wanting to be labelled as 'sick' (Buchholz et al., 2017; waldeneatingdisorders.com, n.d.). There is a huge amount of stigma associated with eating disorders, in fact stigma against eating disorder sufferers is greater than that against patients with depression (Roehrig & McLean, 2010), and this attitude persists even given the wealth of information that we now have about these disorders (Ebneter & Latner, 2013). Feelings of being able to 'go it alone' or of not being sick enough for treatment are also highly prevalent among sufferers and serve to maintain a state of denial or prevent them from seeking treatment (Griffiths et al., 2018; waldeneatingdisorders.com, n.d.). Denial can also take the shape of feeling that other commitments, such as family or work, should take priority, or feeling that one's case is not like others represented in the media (Ali et al., 2017; waldeneatingdisorders.com, n.d.). Another barrier put up by sufferers is attachment to one's eating disorder and not seeking treatment for fear of having to let go (Ali et al., 2017; Griffiths et al., 2018). Indeed, Griffiths et al. postulate that only 23% of individuals with eating disorders seek treatment.

1.2.5. Lack of Recognition of Eating Disorders by Professionals

Besides the barriers put up by the sufferers themselves for various reasons, there are also difficulties to ED recognition that emanate from the professionals who come into contact with them. Cain et al. (2017) state that the most significant barriers faced by ED sufferers in accessing treatment is lack of knowledge of the disorders in general and negative attitudes towards eating disorder sufferers.

Often those who are in contact with sufferers do not recognise the signs as belonging to an eating disorder (Bullivant et al., 2019; Hay et al., 2007; Reid et al., 2009). Research has shown that poor mental health literacy among professionals "may contribute to low rates of recognition" (Hay et al. 2007, p. 59; Mond, 2014). Bullivant et al. (2019) found that a number of professionals such as teachers, public health workers, personal trainers, etc., felt that they had not received enough information about eating disorders in their professional training, and in fact, some had not received any information or training at all. Mond adds that poor eating disorder mental health literacy among primary care practitioners could make them unsure about how to treat patents or what course of treatment would be best for their case.

For example, Reid et al. (2009) found that, although 59% of eating disorder sufferers in the UK visit their GP, only 15% felt that their practitioner understood their condition and could offer effective help. Buchholz et al. (2017) state that primary care providers correctly identify less than 10% of persons with eating disorders. Waller et al. (2014) point out that, given that there is a discrepancy between eating disorder incidence figures and the number of practitioner diagnoses, it stands to reason that a number of eating disorders are not being identified at practitioner level. Thus, although ED sufferers are prolific users of public healthcare systems, the detection and diagnosis of eating disorders remains low (Hay et al., 2007). Caine et al. (2017) believe that the principal reason for this is that "practitioners may have limited diagnostic knowledge or hold inaccurate beliefs about people with EDs, which may lead to symptoms of an ED being overlooked or misclassified" (Cain et al., 2017, p. 2). Waller et al. (2014) posit that the requirement for general practitioners to have a wide knowledge base, means that they are less knowledgeable about rare conditions such as eating disorders, while Currin et al. (2009) propose that such gaps in physician knowledge necessitate a deeper training of EDs for physicians, as well as easy access to an information database that can be accessed when needed. Medical practitioner knowledge of EDs certainly needs to be boosted, as missed diagnoses mean that opportunities for early detection and intervention are overlooked, resulting in a longer and more difficult recovery (van Son et al., 2010).

In education settings, identification of eating disorders is similarly problematic, not least as the youngsters concerned may exhibit signs of disordered eating or a sub-clinical eating disorder rather than a full-blown disorder as categorised in the diagnostic criteria (Hellings & Bowles, 2007). Recognition of ED symptomatology in this setting is of particular importance, since childhood and adolescence are critical ages for the emergence of eating disorders (Treasure et al., 2010), and as stated above, the earlier these disorders are recognised and treated, the better the outcome. In addition, schooling lost due to eating disorder treatment and recovery exerts long-term effects on the child's future (Hellings & Bowles, 2007). Despite these challenges, educators, who spend extended amounts of time with their charges, are excellently positioned to assist in recognition of symptoms (Knightsmith et al., 2014; McVey et al., 2003). Bullivant et al. (2019) point out that although

practitioners, educators and other professionals are likely to have knowledge and training regarding obesity, they are less likely to have the same information about eating disorders. They emphasise that it is about time that importance is given to eating disorders as well as obesity. Both can and do affect young people, moreover a person suffering from obesity could also be affected by an eating disorder such as binge eating – they are not necessarily separate issues. Educators should be trained to look out for signs of eating disorders, specifically as they manifest in school settings, such as high preoccupation with food, shape and weight, and signs of disordered eating (Gowers & Bryant-Waugh, 2004, as cited in Hellings & Bowles, 2007). Another way in which educators can help the young people in their care is to include material in the curriculum and in individual lessons to dispel social media myths about thinness, idealised figures and what is and is not achievable in real life; information about how social media images are curated and enhanced; and education in general about what constitutes healthy eating, that diets can quickly spiral out of control and that eating disorders are dangerous (danaemercer, n.d.; Knightsmith et al., 2014).

Sport settings have been perceived to hold correlations with eating disorders, particularly competitive sports that require a combination of litheness and agility, or strength and muscularity (Mitchison & Hay, 2014; Stoutjesdyk & Jevne, 1993). The pressure to fit one's body to sporting criteria and the discipline required for certain sports lend themselves easily to the self-control required to maintain an ED, particularly of the restraining type. Stoutjesdyk & Jevne (1993, pp. 279-280) state that "as a group, athletes, are not at higher risk for eating disorders than the general population; however, there is evidence that certain subgroups of athletes may be at greater risk than others". They make a link between the unique pressures and expectations in high performance sports and a tendency towards eating disorders (Stoutjesdyk & Jevne, 1993). Nowicka et al. (2013) highlight that other studies have shown that, although sport coaches are not usually responsible for these leanings towards EDs, they can play a vital role in reducing any tendencies towards disordered eating. Due to "daily and intensive contact with athletes, [they] are in a unique position to identify the early signs of ED and direct athletes to professional help" (Nowicka et al., 2013, p. 344). Furthermore, since athletes ascribe high importance to their coaches, any prevention or treatment programme is unlikely to succeed without the support of the coach (Martinsen et al., 2015). Yet, the same barriers are encountered in sporting disciplines as in the other areas examined in this report. Eating disorders are hard to identify and sport coaches too report that they feel they are not knowledgeable enough about nutrition and eating disorders, and state that they do not feel competent identifying and speaking to their athletes about eating disorders (Nowicka et al., 2013; Vaughan et al., 2004). Vaughan et al. (2004) report that where training institutions have in place an eating disorder policy to assist coaches in ED recognition and provide clear guidelines for manging athletes with eating disorders, these are well met and successful.

Studies of professional knowledge of eating disorders in other fields is scarce or non-existent (Levine, 2017; Worsfold & Sheffield, 2019 & 2018). Buchholz et al. (2017) argue for the inclusion of psychologists in primary care settings as they are more likely to correctly identify an eating disorder. Indeed, Worsfold & Sheffield, in their 2019 and 2018 examination of the eating disorder knowledge of psychologists, naturopaths and fitness instructors, found that psychologists had the best knowledge of EDs. However, ED knowledge was lacking across all three areas of practice, especially if the ED was atypical, such as non-purging bulimia. Despite the higher levels of ED knowledge found for psychologists, who are in general expected to receive more training about eating disorders than naturopaths and

fitness instructors, confidence in ED knowledge was found lacking for all three professions. In their 2018 study, Worsfold & Sheffield (2018) found that in some cases, sufferers were actually given advice that maintained or even worsened their disorder, such as when they were praised for their training or dieting discipline. In their 2019 study, they found that 72% out of 115 practitioner participants did not routinely screen for EDs and that over half had difficulty recognising the presence of an eating disorder when weight was within a healthy measure. Moreover, in a subsequent study (Worsfold & Sheffield, 2021) they found that practitioners' personal beliefs such as "thin-ideal internalization, orthorexia [obsession with health eating], health or fitness mindset and gender role identity" could hinder ED detection (p. 296). This suggests that as well as examining professionals' ED knowledge, it would be helpful to look at their personal beliefs and characteristics.

Maguire et al. (2019) make an interesting case for the provision of eating disorder education to be held online. In their 2019 study, the authors examined 1,813 professionals who had participated in an online learning course. From their pre- and post- training assessments, they determined that professionals who had followed at least 80% of the training felt more confident and knowledgeable and had more positive attitudes towards people presenting with EDs or suspected EDs. This raises the possibility of utilising online teaching methods in order to reach a wide range of professionals in a cost-effective way.

Inadequate professional knowledge of EDs and patient evasiveness are not the only barriers to ED recognition. Stein (2006) points out that health care practitioners see a greater number of people presenting with sub-clinical variants of eating disorders, rather than sufferers whose disorder slots neatly into the diagnostic criteria. This, together with the likelihood of the person themselves obfuscating the issue, adds a further layer of difficulty when it comes to diagnosing eating disorders. Additionally, when the sufferer comes from a different background to the clinician, there is the risk of miscommunication (Stein, 2006). Stein suggests that first contact professionals ought to be aware that a different ethnicity, culture, language or even gender may lead to differences in how food is consumed, regarded or even spoken about, and that these factors can also create obstacles to ED recognition. Sociocultural and transcultural issues are becoming ever more relevant as the world becomes increasingly interconnected.

1.2.6. Lack of Professionals' Recognition of Eating Disorders in Malta

Awareness and treatment of eating disorders in Malta has advanced rapidly in the last decade, especially with the setting up in 2014 of Dar Kenn għal Saħħtek, a residential and semi-residential facility providing holistic treatment for eating disorders and obesity (Falzon Aquilina, 2015; Grech, 2013). Although research into knowledge of eating disorders among professionals in Malta is minimal, a few investigations do exist, mainly pertaining to ED knowledge among education, health care and mental health professionals. One finding that does emerge from the existing studies is that gaps do exist in professional knowledge of eating disorders, as well as deficiencies in public awareness (Chetcuti, 2020; Orsini, 2017).

Within educational settings, Micallef (2003), Mercieca (2011) and Barthet (2013) all found that knowledge of EDs was greatly lacking not only among students and their families, but also among educators. Micallef (2003) found that educators do not feel confident in their knowledge about EDs in general. Similarly, Mercieca (2011) found a general lack of eating

disorder knowledge in educational institutions, reporting also that teachers find it difficult to know how to tackle the subject.

The situation among primary health care professionals is similar. Esposito (2008) found that in Malta, as elsewhere, general practitioners may have stereotyped notions of eating disorders as mainly affecting young females, which could lead them to underdiagnose EDs in males and other non-typical demographics. Meanwhile the experience of psychologists and other mental health care professionals has been more widely studied, however the general situation is similar. Agius (2015), who examined the experience of psychologists working with eating disorder patients, concluded that psychologists did not feel that their formal instruction was deep enough to enable them to feel confident in treating ED patients, necessitating further specialised study. Agius also highlighted the need for dedicated courses to be periodically provided as part of psychologists' ongoing professional development. These findings were reflected in Chetcuti's 2020 research examining health care professionals' understanding of Orthorexia Nervosa (ON). Although ON is not currently recognised as a separate diagnosis under the DSM-5, it is gaining recognition as a stand-alone condition (Cena et al., 2019). Chetcuti found that there are gaps and inconsistencies in health care professionals' (HCPs) knowledge of EDs and that although HCPs are aware that current cultural trends can exert an impact, nevertheless such trends, such as the enthusiasm for fitness and health topics that is so extant on social media and in common cultural expression. These movements can and do exert an undue influence even on professionals. Chetcuti found that psychologists tend to be more knowledgeable about EDs than other practitioners, such as dieticians or fitness instructors, which mirrors the findings of Worsfold & Sheffield (2019), described above. Practitioners across the board expressed a desire to improve their skills and knowledge, and indicated that continuous professional development is extremely important (Chetcuti, 2020).

Studies examining the ED knowledge of other care providers, such as social workers and youth workers, is once again scarce. However, the pattern emerging from the few studies available is similar to that for other professional practitioners. Muscat (2017) calls for more interventions by social workers and for more to be done in terms of prevention and education in general. There are very few studies that examine the role of social workers in eating disorder situations, however the general finding from extant studies is that social workers certainly do have a role to play (Farrugia, 2004; Camilleri, 2007).

Awareness and response to eating disorders has vastly improved in recent years, particularly with the setting up of a dedicated eating disorder facility in 2014. Yet, a number of studies have found that professionals from various fields of practice do not feel confident in their knowledge of eating disorders and have expressed a wish for more information and training. As well as expressing a need for more information to be imparted at undergraduate or primary training level, there is strong call for ongoing professional development. This would have the added benefit of giving practitioners the confidence to diagnose the presence of an ED and feel competent in discussing these delicate issues with persons they suspect of having an eating disorder.

1.3. CONCLUSION

Given the pain and anguish that eating disorders cause sufferers and their families, as well as the challenges they cause to the health provision sector, it is imperative that EDs are caught early. The earlier that an eating disorder is detected and treated, the better the outcome. However, given that EDs are hard to detect and that sufferers tend to be in denial or secretive about their disorder, early diagnosis is difficult to achieve. Added to this is the fact that several professionals that come into frequent contact with persons with suspected or emergent eating disorders feel that they do not have a profound enough knowledge to feel confident speaking to possible sufferers or diagnosing eating disorders.

This makes a strong argument for more education about eating disorders to be given at formative training level, as well as providing dedicated continuous development courses for professionals that are already in employment and top up courses for those professionals working directly with eating disorder patients. Stein (2006) also suggests that professional practitioners should be provided with information about atypical manifestations of eating disorders and about how eating disorders show up in persons from diverse cultures, ethnicity and gender. Additionally, an awareness of how they manifest in children would be beneficial, as ED symptomatology for children differs from that in adults, which could impact diagnostic accuracy (Stein, 2006). At treatment level, Bullivant et al. (2019) emphasise the importance of cross-sectoral collaboration and communication, for example between clinicians and educators, as means of enriching collaboration and proving better treatment and reducing stigmatising beliefs in practitioners.

Any provision of information and education to professionals from diverse fields of practice who may be in a position to spot an emerging eating disorder and provide assistance, counsel and suggestions for professional treatment, would greatly serve to improve the confidence and mental health literacy of professionals. This will ultimately help to improve the future chances of sufferers by saving them from years of entanglement with an excruciating disorder and subsequent challenging and prolonged treatment needed to free themselves from their eating disorder.

Chapter 2
Methodology

This section of the report explains the methodology adopted in this study. It presents the research questions underpinning the study and the mixed-methods research design implemented to engage with the research questions. It also discusses the choice of data-gathering tools, strategies for gaining access to participants, and sampling and recruitment strategies. It goes on to explain the methods adopted to analyse the qualitative and quantitative data, ethical considerations and ways in which potential shortcomings of the study were addressed.

2.1 RESEARCH AGENDA AND RESEARCH QUESTIONS

The research questions guiding this study were:

(iv) What is the state of knowledge of eating disorders of professionals who may be first-point-of-contact for potential sufferers?

(v) How confident do first-contact professionals feel in talking to persons they suspect may have an eating disorder?

(vi) How can the health sector and Dar Kenn għal Saħħtek respond to these challenges?

2.2 DATA GATHERING TECHNIQUES

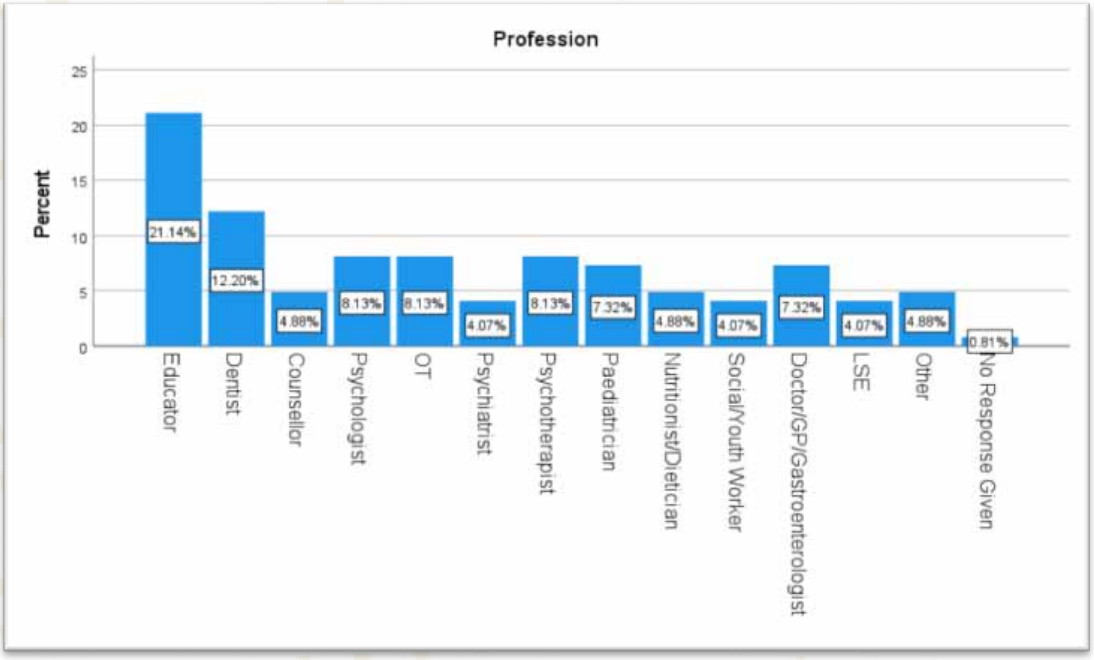
The theoretical and academic framework for the project was set by analysing academic literature, reports and documents relating to eating disorder knowledge among professionals hailing from diverse fields of practice, in order to gain in-depth insight into the subject. Additionally, local documents and reports were examined to identify how such eating disorder knowledge among professionals in Malta has been examined to date, explore professionals' gaps in knowledge and their information needs, and to evaluate plans to deliver further education and courses.

Primary data was generated through a mixed quantitative and qualitative methodology. Quantitative data was collected via an online questionnaire, which was sent to professionals, including psychologists, teachers, doctors, social workers, nutritionists and other service providers; and qualitative data was assembled from four focus groups held with different professionals, in order to examine the research questions in further depth.

The questionnaire was designed to provide a general picture of the eating disorder knowledge of professionals in Malta and was sent as an online form. The form was sent to 24 professional associations and 5 private entities, asking them to forward the questionnaire to their members or professionals, and to publicise it in their newsletter or on social media, in order to attract the best possible number of responses. Uptake from the associations was good and replies were submitted from 12 different professions or areas of professional interest (Figure 2.1, below). The questionnaire itself was created by the research team, based on findings in the literature and on data gathering instruments from similar studies. It was piloted with a group of 6 professionals from different areas of practice, genders and ages, to ensure that it was understandable and to test for any problems. Some minor amendments were made to the questionnaire as a result of this piloting exercise. The questionnaire in its final form was disseminated in English. As well as general data such as age; gender; field, length and locality of practice; respondents were asked to respond to 8 true or false statements about each of

the following categories: anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant/restrictive food intake disorder and general eating disorder knowledge. They were also asked about their experience with and attitude to eating disorders, such as whether they think that EDs affect males, or how they would feel approaching person they suspect of having an ED. The questionnaire went on to ask respondents to rank their preference for ED service delivery from hospital, health centre, local council or pharmacy. A total number of 123 valid responses from 12 different professional areas of interest were received, Figure 2.1 (below) refers. The questionnaire is attached in Appendix A.

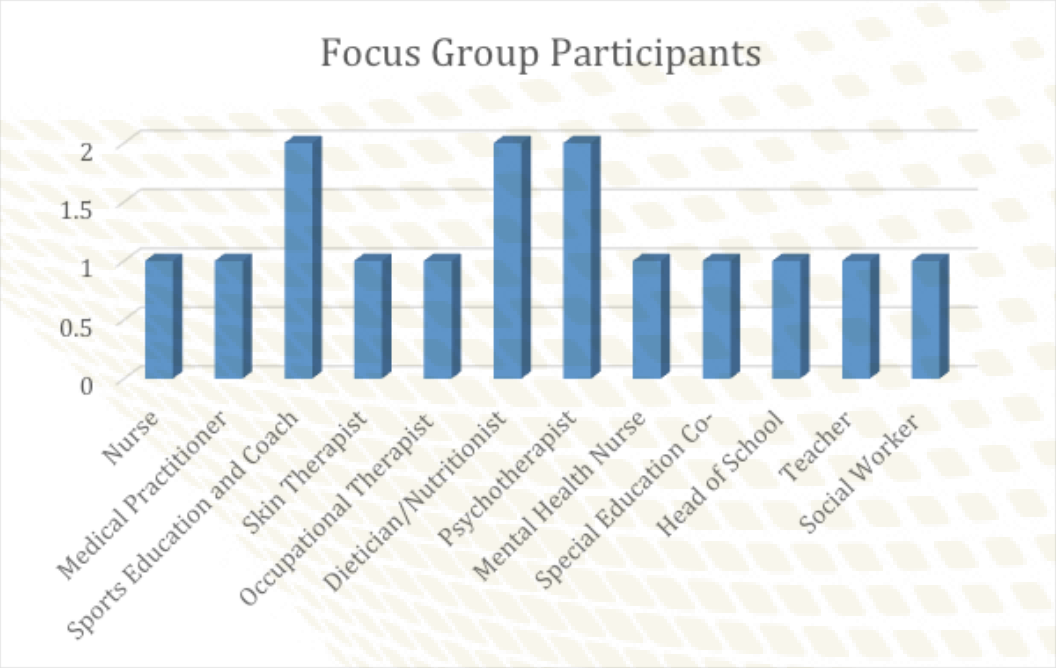
Figure 2.1. Questionnaire Participants by Profession



In order to gain a deeper understanding of the depth of eating disorder knowledge and gaps within that knowledge, four focus groups were conducted with a total of 15 representatives coming from various professions (Figure 2.2). Focus Group 1 (FG1) was held with persons from the Medical Professions and two participants took part. Another two were due to join the Focus Group, but could not make it at the last minute. Focus group 2 (FG2) was composed of 6 professionals from Food and Sports, while for Focus Group 3 (FG3), 3 persons were from the area of Mental Health, and Focus Group 4 (FG4) was held with 4 persons from the Education and Caring Professions.

The focus groups took a more detailed and closer look at how professionals from the various fields experienced eating disorders, their knowledge of the subject and their confidence in speaking to possible sufferers. Finally, a number of thoughts and suggestions for the future were discussed. The focus group interview guide is attached in Appendix E.

Figure 2.2. Focus Group Participants



2.3 SAMPLING AND RECRUITMENT STRATEGY

For the questionnaire, a purposive sampling strategy was used. A wide range of professional practitioners were targeted who, through their professional practice, could be instrumental in recognising a potential eating disorder and assisting the person by pointing them in the direction of diagnosis and treatment.

Access was obtained via the professional associations for the selected professions, which were asked to disseminate the questionnaire to their members and publicise it on their Facebook page or newsletter. A total of 24 associations from 17 fields of professional practice were contacted and responses were received from diverse areas of practice (Table 2.1). In addition, Malta's 4 main private hospitals and 4 larger dental clinics were also contacted and asked to disseminate the questionnaire to their professional staff.

Recruitment for the Focus Groups was carried out via gate keepers, such as Dar Kenn għal Saħħtek, and by direct recruitment. 15 participants participated in four focus groups. For both questionnaire and Focus Group invitations, the recruitment email contained information about the research study, its objectives and methods, as well as assurances regarding ethical considerations in line with GDPR.

Table 2.1. Professional Associations that were asked to forward the questionnaire to their members

Area of Practice	Association Contacted
Teachers, LSEs, Heads of School	Malta Union of Teachers
Psychologists	Malta Chamber of Psychologists
	Malta Adlerian Psychology Association
	The Malta Depth Psychological Association
Psychotherapists	Malta Association for Psychotherapy
Psychiatrists	Maltese Association of Psychiatry
Counsellors	Malta Association for the Counselling Profession
General Practitioners, Family Doctors, Nurses	The Medical Association Malta (MAM)
	Malta Association of Public Health Medicine
	Malta College of Family Doctors
	Malta Association of Physicians
Paediatricians	Maltese Paediatric Association
Gynaecologists	Malta College of Obstetricians & Gynaecologists
Dentists	Dental Association of Malta
Social Workers	Maltese Association of Social Workers
Youth Workers	The Maltese Association of Youth Workers
Nutritionists/Dieticians	Council for Professions Complimentary to Medicine
Sports Trainers/ Personal Trainers/ Fitness Instructors	Malta Exercise Health and Fitness Association
Physiotherapists	Malta Association of Physiotherapists
Pharmacists	Pharmacy Council
Nurses	Malta Union of Nurses and Midwives
Psychiatric Nurses	Maltese Association of Psychiatric Nurses
Occupational Therapists	Maltese Association of Occupational Therapists

2.4 DATA ANALYSIS

123 valid responses to the questionnaire were received. The data gathered was cleaned using Microsoft Excel and subsequently analysed using SPSS (Statistical Package for the Social Sciences) version 26. Descriptive statistics were used mainly to summarise the socio-demographic characteristics of the cohort. Crosstabs and means testing were used to further analyse the results and test for statistically significant associations between variables. Results were considered to be statistically significant if the p-values were less than or equal to 0.05. The internal consistency was evaluated using Cronbach's alpha coefficient, as was the consistency for the individual items of the questionnaire.

The data obtained via the focus groups was analysed using thematic analysis. Thematic analysis enables an accessible and theoretically flexible approach to analysing data (Braun & Clarke, 2006). Following transcription, the data was closely analysed and initial codes were generated, which enabled further analysis of emergent themes. Meaning was extracted from the common themes, topics and patterns that emerged.

2.5 ETHICAL CONSIDERATIONS

An Ethics & Data Protection (E&DP) form was submitted for the records of the Faculty Research Ethics Committee (FREC) of the Faculty for Social Wellbeing of the University of Malta on 1st March 2021, and approval was obtained on 20 May 2021. This research is in conformity with the University of Malta's Research Code of Practice and Research Ethics Review Procedures.

Gatekeepers and potential participants were provided with all details about the study, as well as their rights as a research participant and according to General Data Protection Regulations (GDPR). Recruitment and Consent Forms presented the nature and scope of the study. The anonymity of questionnaire respondents was guaranteed via a questionnaire design that did not collect any identifiable data such as names or email addresses, and for the Focus Groups, potentially identifiable participants were informed that they will be referred to by a pseudonym, rather than by any other means through which identifications could be possible. No compensation was offered for participation.

2.6 POTENTIAL LIMITATIONS OF THE STUDY

Notwithstanding the strengths of this study, such as the use of targeted purposive sampling of persons from professions that could bring them into contact with potential eating disorder sufferers, the study is not without limitations. Although purposive samples efficiently reach the target population, the research team has no control over the number of responses received from each field of professional practice, with the result that some professions were highly responsive, while other fields of practice are under-represented. For example, despite various efforts being made to engage persons from the nursing profession in the questionnaire, no replies were received from nurses. This was however somewhat compensated for by the mixed methods nature of the research design, and gaps perceived in the questionnaire respondents were compensated for in the focus group recruitment of participants. The lack of responses from nurses was compensated for by actively engaging to recruit nurses/ mental health nurses in the focus groups. It was also noted that the questionnaire respondents were overwhelmingly female. Smith (2008) states that gender does influence survey response, with females being more prone to respond, however other factors should also be taken into consideration, such as interest in the subject being studied and gendered behaviour in online spaces.

Chapter 3
Study Findings and Discussion

This section of the report will examine the findings extracted from the quantitative and qualitative data and will discuss the significance of these findings in the light of professional knowledge and attitudes to eating disorders.

3.1. FINDINGS FROM THE QUESTIONNAIRE

The questionnaire was created by the research team for the purposes of this study and was entitled ED Knowledge Among Professionals Questionnaire. The items related to eating disorder knowledge were tested for internal reliability using the Cronbach's Alpha test, which examines how consistently the questionnaire measures the outcome, in this case, respondents' knowledge of eating disorders (Taber, 2018). The Cronbach's Alpha for the items examining ED knowledge was 0.85, which denotes good internal consistency (Price et al, 2017).

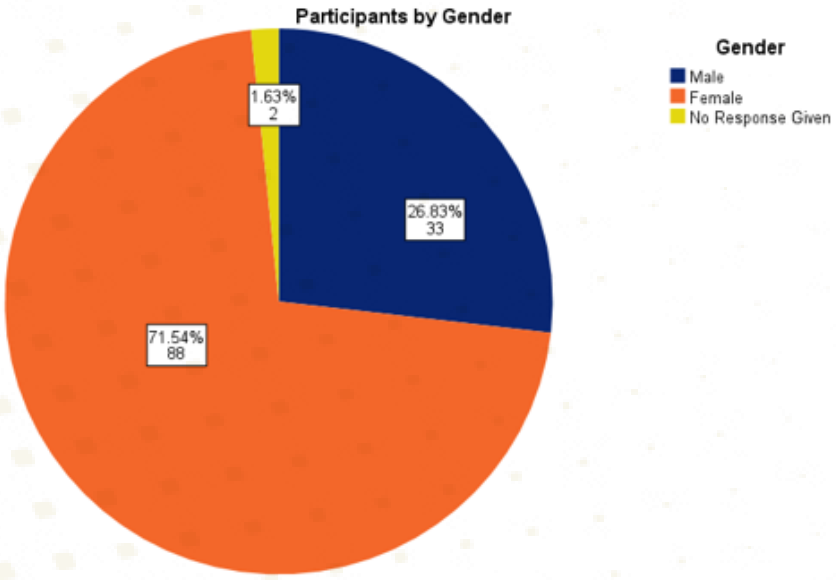
3.1.1 Questionnaire Respondents

Sample recruitment was via the professional associations, who sent a recruitment email to their members or put the information on their website, Facebook page or similar. The ED Professional Knowledge questionnaire was sent for onward dissemination to 24 professional associations and Malta's 4 main private hospitals. It was also sent to a number of private enterprises, such as the larger dental clinics, particularly where the research team noted that replies from a certain area of practice were scant. 123 valid responses were received across a number of professional areas of practice. Of the 121 respondents who wished to specify their gender, 72.7% (n=88) were female and 27.3% (n=33) were male, as demonstrated in Figure 3.1, below.

Participant ages ranged from under 25 to over 60 (Table 3.2), with the majority being between 31 and 40 years of age. Participants were also asked how long they have been practicing their professions, with respondents pretty evenly placed across the ranges (Table 3.3); and locality of practice, where it was seen that the majority of participants, 42.3% (n = 52) practice in the Northern Harbour region, followed by 20.3% who practice in the Southern Harbour Region (n = 25), and with only 4% (n = 5) practicing in the Gozo and Comino Region, (Figure 3.2).

Respondents' knowledge of eating disorders (EDs) was tested by having sets of 8 statements each for Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Avoidant/Restrictive Food Intake Disorder (ARFID) as well as another set of 8 statements about eating disorders (EDs) in general. Respondents were asked to mark each statement as 'True', 'False' or 'Don't Know'; where the right reply carried 1 point, such that the total score for each section of AN, BN etc., was 8; while the maximum total score for overall ED knowledge was 40.

Figure 3.1. Participants by Gender



Additionally, respondents were asked about their experience and attitudes to eating disorders, such as whether they ask clients about eating disorders, if they screen for eating disorders, how hard they find it to approach clients to discuss a potential eating disorder, how much of a problem they think EDs are in Malta, and whether they think males are affected. Participants were also asked where they would prefer ED services to be delivered – Hospital, Local Council, Pharmacy or Health Centre.

Table 3.1. Questionnaire Respondents by Profession

		Frequency	Percent
Valid	Educator	26	21.1
	Dentist	15	12.2
	Counsellor	6	4.9
	Psychologist	10	8.1
	OT	10	8.1
	Psychiatrist	5	4.1
	Psychotherapist	10	8.1
	Paediatrician	9	7.3
	Nutritionist/Dietician	6	4.9
	Social/Youth Worker	5	4.1
	Doctor/GP/Gastroenterologist	9	7.3
	LSE	5	4.1
	Other	6	4.9
	No Response Given	1	0.8
	Total	**123**	**100.0**

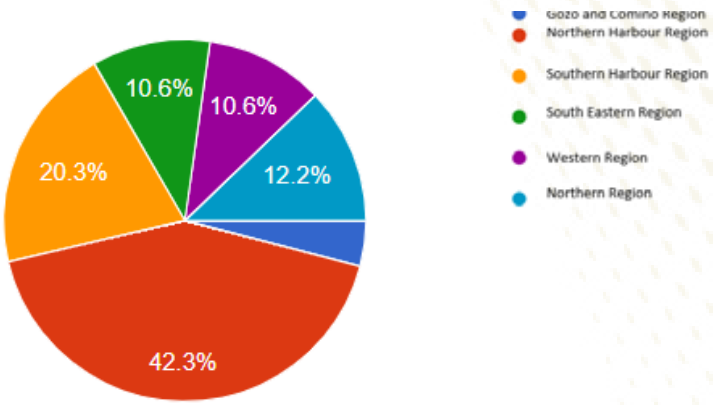
Table 3.2 – Participants by Age

Age Range		
	Frequency	Percent
Under 25	6	4.9
25 – 30	20	16.3
31 – 40	37	30.1
41 – 50	30	24.4
51 – 60	24	19.5
Over 60	5	4.1
No Response Given	1	0.8
Total	**123**	**100**

Table 3.3 – Participants by Length of Professional Practice

Length of Practice		
	Frequency	Percent
Less than 5 years	24	19.5
5-9 years	25	20.3
10-14 years	21	17.1
15-20 years	18	14.6
Over 20 years	35	28.5
Total	**123**	**100**

Figure 3.2. Participants' Region of Professional Practice



3.1.2. Questionnaire Responses

Section 2 of the ED Professional Knowledge Questionnaire sought to observe the ED knowledge of the professionals taking the survey. The first section asked respondents to reply 'Ture', 'False' or 'Don't Know' to 8 statements about 5 areas of eating disorders: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED), Avoidant/ Restrictive Food Intake Disorder (ARFID) and General ED Knowledge (Gen ED); where for some of the statements the right reply was 'True' and for others the right reply was 'False'. This was done to ensure a more accurate measurement of respondents' knowledge by minimising the scope for agreement bias and reducing opportunity for creating repetitive response patterns that may induce inattentiveness in replying (Hopper, 2021). All correct answers received 1 point, with 8 points being the maximum possible score.

Examining the Mean Scores for the section on Anorexia Nervosa, the overall mean was a rather high 6.53. Observing the mean score per profession, the lowest mean was of 5.40 for the profession of Social/Youth Workers, while the highest mean of 7.50 was obtained for the profession of Psychotherapist. The lowest score was obtained by a person with the profession of Doctor/GP/Gastroenterologist while the maximum score of 8 was achieved by a number of individuals within the professions of Educator, Dentist, Psychologist, OT, Psychiatrist, Psychotherapist, Paediatrician, Nutritionist/Dietician, and Social/Youth Worker and LSE (Learning Support Assistant). This indicates that professional practitioners have a good overall knowledge of Anorexia Nervosa. Table 3.4 refers.

Table 3.4 – Mean Scores for Knowledge of Anorexia Nervosa

	Mean for Total AN Scores				
Profession	Mean	N	Std. Deviation	Minimum	Maximum
Educator	6.35	26	1.355	3	8
Dentist	6.40	15	1.298	4	8
Counsellor	5.83	6	.983	4	7
Psychologist	7.40	10	.699	6	8
OT	6.50	10	1.354	4	8
Psychiatrist	7.20	5	1.304	5	8
Psychotherapist	7.50	10	.527	7	8
Paediatrician	6.89	9	.601	6	8
Nutritionist/Dietician	7.33	6	.816	6	8
Social/Youth Worker	5.40	5	1.673	4	8
Doctor/GP/Gastroenterologist	5.67	9	1.936	1	7
LSE	5.80	5	1.483	4	8
Other	6.67	6	.816	6	8
No Response Given	4.00	1	.	4	4
Total	**6.53**	**123**	**1.326**	**1**	**8**

The Mean Score for ED Knowledge of Bulimia Nervosa (BN) was 5.96, indicating that across all professions there is less knowledge of bulimia than of anorexia, although of the two, bulimia is more prevalent. Examining mean score per profession, the lowest mean, 5.10, was obtained by the Occupational Therapy profession, while the highest mean, 7.17 was obtained within the Nutritionist/Dietician profession group. The lowest score, 2, was obtained within the profession of Doctor/GP/Gastroenterologist, however within this profession there were also a number of individuals who obtained the highest possible score of 8, which was also obtained by various individuals from most of the other professions, indicating a good overall knowledge of Bulimia Nervosa (Table 3.5).

Table 3.5 – Mean Scores for Knowledge of Bulimia Nervosa

	Mean for Total BN Scores				
Profession	Mean	N	Std. Deviation	Minimum	Maximum
Educator	5.54	26	1.392	3	8
Dentist	5.93	15	1.792	3	8
Counsellor	6.00	6	1.414	4	8
Psychologist	6.20	10	1.135	4	8
OT	5.10	10	1.449	3	8
Psychiatrist	6.80	5	.837	6	8
Psychotherapist	6.20	10	1.033	5	8
Paediatrician	7.00	9	.866	6	8
Nutritionist/Dietician	7.17	6	1.329	5	8
Social/Youth Worker	5.20	5	1.304	4	7
Doctor/GP/Gastroenterologist	6.33	9	1.732	2	8
LSE	5.40	5	.548	5	6
Other	5.67	6	.516	5	6
No Response Given	5.00	1	.	5	5
Total	**5.96**	**123**	**1.393**	**2**	**8**

Looking at the Mean Scores for Binge Eating Disorder shows an overall mean of 5.99, with a lowest mean of 5.10 for the profession of Occupational Therapy and a highest mean of 7.10 obtained for the profession of Psychologists. The lowest score was obtained within the profession of Educators, while the maximum score of 8 was achieved by a number of persons within the professions of Dentist, Psychologist, OT, Psychotherapist, Paediatrician and Nutritionist/Dietician, indicating that a good knowledge of BED is less widespread than for AN and BN. Table 3.6 refers.

The Mean Scores for ARFID display an overall mean of 4.80, which is appreciably lower than the mean scores for the other EDs and indicates that across the EDs, ARFD is the one about

which there is least knowledge among professionals. The lowest mean of 3.15 occurred for the profession of Educators, and a highest mean of 6.67 was obtained by the profession of Nutritionist/Dietician. A score of 0 was obtained within the professions of Educator, Dentist, Occupational Therapist, Paediatrician and Doctor/GP/Gastroenterologist. The maximum score of 8 was achieved by a number of persons within the professions of Dentist, Counsellor, Psychologist, OT, Paediatrician and Nutritionist/Dietician, indicating that despite there being a need for more knowledge of ARFID, overall professional practitioners do have knowledge of ARFID (Table 3.7, below).

Table 3.6 – Mean Scores for Knowledge of Binge Eating Disorder

Mean for Total BED Scores					
Profession	Mean	N	Std. Deviation	Minimum	Maximum
Educator	5.42	26	1.629	0	7
Dentist	5.93	15	1.387	3	8
Counsellor	6.67	6	.816	5	7
Psychologist	7.10	10	.316	7	8
OT	5.10	10	2.234	2	8
Psychiatrist	6.60	5	.894	5	7
Psychotherapist	6.60	10	1.430	4	8
Paediatrician	6.56	9	1.130	4	8
Nutritionist/Dietician	6.67	6	1.033	5	8
Social/Youth Worker	5.20	5	1.095	4	7
Doctor/GP/Gastroenterologist	5.78	9	1.716	3	7
LSE	5.80	5	.447	5	6
Other	6.00	6	1.265	4	7
No Response Given	4.00	1	.	4	4
Total	**5.99**	**123**	**1.479**	**0**	**8**

Similarly, the mean scores obtained for the section examining General Knowledge of Eating Disorders reveals a mean overall score of 6.46. This section examined common or main beliefs about eating disorders in general, rather than particular attributes of the different EDs. The lowest and highest means were obtained within the professions of Social/Youth Worker and Nutritionist/Dietician respectively. The lowest score of 3 being was obtained by individuals in the profession of Educator, Occupational Therapist and Doctor/GP/Gastroenterologist, however all professions had overall high scores with maximums of 8 or 7 throughout. Table 3.8 refers.

A summation of all the scores for all ED categories for each individual allowed for observation of total scores for ED Knowledge of both the individual disorders and of overall ED awareness. The mean for total scoring was 29.74, with a standard deviation of 5.74. This mean, of practically 30 out of a maximum possible score of 40, indicates a good knowledge of both the individual eating disorders as well as of eating disorders in general across all professions. The highest mean, 35.5, was achieved for the profession of Nutritionist/Dietician, while the lowest mean of 26.5 was achieved for the profession of Educator (Table 3.9).

In order to statistically analyse the data, the 'professions' variable was re-coded into wider groupings, whereby Educator and LSE were placed together in a group named 'Education Professionals'; Counsellors, Psychologists, Psychiatrists and Psychotherapists were placed together in the group 'Mental Health Professionals', another group for 'Medical Professionals' was put together, consisting of Dentists, Paediatricians and Doctors/GPs/Gastroenterologists; while a fourth grouping was made for 'Caring and Allied Health Professionals', consisting of Occupational Therapists, Nutritionists/Dieticians and Social/Youth Workers.

Table 3.7 – Mean Scores for Knowledge of Avoidant/Restrictive Food Intake Disorder

	Mean for Total ARFID Score				
Profession	Mean	N	Std. Deviation	Minimum	Maximum
Educator	3.15	26	2.034	0	6
Dentist	3.87	15	2.669	0	8
Counsellor	5.67	6	1.366	4	8
Psychologist	6.50	10	.972	5	8
OT	4.50	10	2.799	0	8
Psychiatrist	6.40	5	.894	5	7
Psychotherapist	4.70	10	2.359	0	7
Paediatrician	6.33	9	2.500	0	8
Nutritionist/Dietician	6.67	6	1.033	5	8
Social/Youth Worker	5.00	5	1.000	4	6
Doctor/GP/Gastroenterologist	4.56	9	2.068	0	6
LSE	5.80	5	1.095	5	7
Other	4.83	6	2.714	0	8
No Response Given	6.00	1	.	6	6
Total	**4.80**	**123**	**2.326**	**0**	**8**

Table 3.8 – Mean Scores for General Knowledge of Eating Disorders

	Mean for Total Gen ED Scores				
Profession	Mean	N	Std. Deviation	Minimum	Maximum
Educator	6.04	26	1.341	3	8
Dentist	6.27	15	1.033	5	8
Counsellor	6.50	6	1.049	5	8
Psychologist	7.10	10	.876	6	8
OT	6.70	10	1.636	3	8
Psychiatrist	7.20	5	.837	6	8
Psychotherapist	6.70	10	.675	6	8
Paediatrician	7.00	9	1.323	5	8
Nutritionist/Dietician	7.67	6	.516	7	8
Social/Youth Worker	5.80	5	1.304	4	7
Doctor/GP/Gastroenterologist	6.22	9	1.394	3	7
LSE	6.00	5	.707	5	7
Other	5.67	6	1.506	3	7
No Response Given	6.00	1	.	6	6
Total	**6.46**	**123**	**1.237**	**3**	**8**

Table 3.9 – Mean Total Scores for Overall Knowledge of Eating Disorders

	Mean for Overall Total ED Scores				
Profession	Mean	N	Std. Deviation	Minimum	Maximum
Educator	26.50	26	5.240	18	37
Dentist	28.40	15	6.080	18	35
Counsellor	30.67	6	4.412	25	38
Psychologist	34.30	10	2.627	29	38
OT	27.90	10	7.430	18	37
Psychiatrist	34.20	5	3.899	28	38
Psychotherapist	31.70	10	4.523	24	38
Paediatrician	33.78	9	4.994	22	38
Nutritionist/Dietician	35.50	6	3.271	31	39
Social/Youth Worker	26.60	5	2.302	24	29
Doctor/GP/Gastroenterologist	28.56	9	6.710	12	35
LSE	28.80	5	2.683	25	31
Other	28.83	6	4.956	21	35
No Response Given	25.00	1	.	25	25
Total	**29.74**	**123**	**5.737**	**12**	**39**

To further examine the data, a One-Way Analysis of Variance (ANOVA) test was performed using SPSS, in order to compare the mean total scores of the different profession groups and determine whether any statistically significant difference exists (Lund Research, 2018). This test returned a result that the mean Total ED test score is statistically significant different for at least one groups of professions ($F3, 535 = 5.994$, $p < 0.001$).

A post hoc test was conducted, in order to analyse where this difference lay. This revealed that the mean total score for Mental Health Professionals is statistical significantly different from that for Education Professionals. Specifically, participants forming part of the Mental Health Professionals group obtained a higher mean score compared to those participants in the Education Professionals group, with a mean difference of 5.87. Whilst differences in mean scores were also observed between other profession groups, none were statistically significant. Nonetheless, it is worth noting that Mental Health Professionals obtained a higher mean score than the other three groups. Table 3.10 refers.

These results demonstrate that Mental Health Professionals possess a statistically significantly greater degree of knowledge with regard to eating disorders, as measured through the entitled ED Knowledge Among Professionals Questionnaire, used in this study, when compared to Education Professionals.

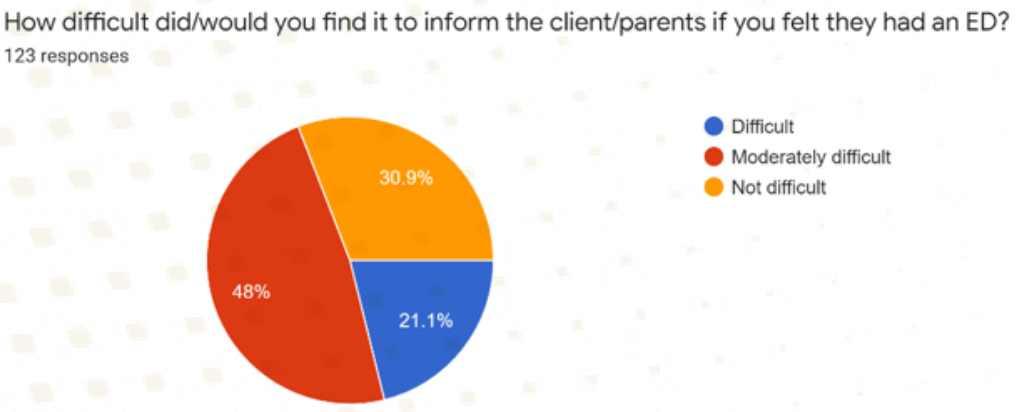
Table 3.10 – Mean Total Scores by Regrouped Professions

	N	Mean	Std. Deviation	Minimum Score	Maximum Score
ːation Professionals	31	26.87	4.958	18	37
ɪtal Health Professionals	31	32.74	3.983	24	38
lical Professionals	33	29.91	6.282	12	38
ŋg and Allied Health Professionals	21	29.76	6.534	18	39
l	**116**	**29.83**	**5.797**	**12**	**39**

The questionnaire also examined respondents' experience and attitudes to eating disorders. When asked whether they ask clients about their eating habits in their professional encounters, respondents overwhelmingly replied in the affirmative, with 79% (n=97) stating that they do. Similarly, 75% (n=92) of respondents stated that they have encountered clients with eating disorders in the course of their professional practice. This was further examined by asking whether they refer clients onwards, where again the majority stated that they do (67%, n-82), although however, 16% (n=20) state that they do not. 70% (n=85) affirmed that they do enquire further about physical symptoms that could indicate an underlying eating disorder. The most startling finding, however, was that only 40% routinely screen for EDs, despite the fact that most respondents started that they have had encounters with persons suffering from EDs in their professional practice. A further 47% also stated that they do feel that in the practice of their profession there is discrimination towards persons who are overweight, which is noteworthy, given that overweight is a potential symptom of binge eating disorder. Finally, 89% (n=109) of respondents claimed that they would like to have more information and/or

training about eating disorders. The questionnaire also explored respondents' attitudes. 44.3% consider EDs to be a major problem in Malta, with a further 51.4% considering them to be a moderate problem and just 1.6% stating that they are only a minor problem, demonstrating that through their professional encounters the vast majority of professionals in Malta are aware that EDs are indeed a problem on the Maltese islands. When asked to consider whether EDs affect males, the majority of professionals in Malta, 91.8% (64.2% = 'Somewhat' and 27.6% = 'A lot') are aware that males are also affected. When asked whether they would find it difficult to inform clients if they thought that they had an eating disorder, 70% reported that they would with 21.1% replying that they would find it difficult and 48% replying that they would find it moderately difficult. A further 38% replied that they would not find it difficult, Figure 3.3.

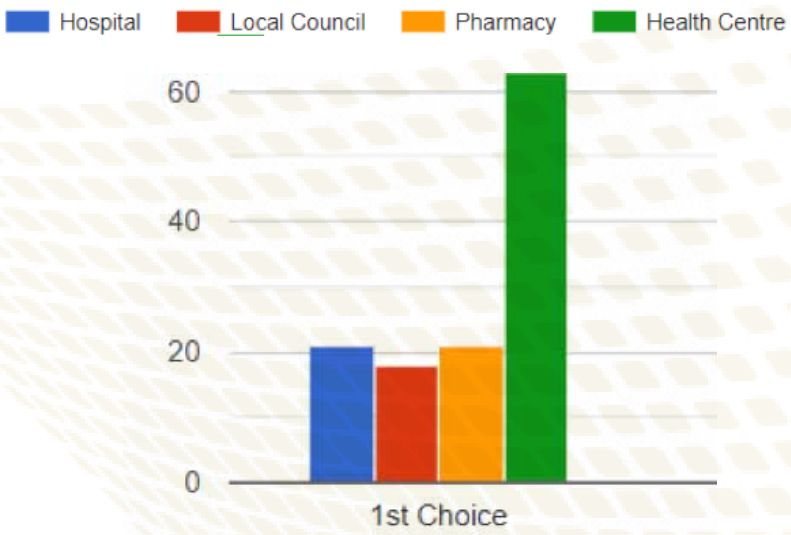
Figure 3.3. How difficult would you find it to inform clients/parents if you felt they had an ED?



Finally, in order to explore reactions to potential settings for delivering eating disorder services in the community, respondents were asked to rank in order of preference where they would prefer ED services to be delivered from hospital. Local council, pharmacy or health centre. The majority of respondents (51%) selected health centres as their first choice, with hospital and pharmacy both receiving equal replies (17%), and the next choice and local councils being the least liked option, with only 15% of respondents selecting this as their first choice.

The questionnaire revealed that overall knowledge of eating disorders among professionals is good. However, there is some discrepancy within professions as well as between the extent of knowledge for the specific eating disorders. For example, the mean score of 4.80 for ARFID shows that this is the ED that is least understood, while the mean of 6.53 for AN, shows that Anorexia is the eating disorder about which there is most knowledge. Rather low standard deviation for all EDs except ARFID shows that although there are discrepancies in knowledge among persons holding the same profession, these are not very large. However, a standard deviation of 2.33 for knowledge of AFRID indicates that even within professions, there is substantial variance of knowledge about this disorder. Table 3.11, below, refers.

Figure 3.4. Eating Disorder service delivery preferences



Where would you prefer an ED service to be delivered – please rank in order of preference:

Table 3.11 – Mean Scores for the Specific Eating Disorders

Mean Scores by Specific ED		
	Mean	Std. Deviation
AN	6.53	1.33
BN	5.96	1.39
BED	5.99	1.48
ARFID	4.80	2.33
Gen ED	6.46	1.24

The questionnaire also revealed that the mental health professionals have statistically significantly better knowledge of eating disorders than educators. This could be due to mental health professionals generally having good mental health literacy, which is linked to the profession, but which is not a requirement in positions in education. Professional practitioners do in general have experience with eating disorders and do ask clients/patients about their eating habits and follow up with them, although this practice could be improved. However, upon suspecting that someone they come into contact with through their profession may have an eating disorder, most professionals would find it difficult to broach the subject, and an overwhelming majority expressed the desire for more training and information about eating disorders.

3.2 FINDINGS FROM THE QUALITATIVE DATA

The research team also conducted four focus groups with medical professionals, mental health professionals, sport and food professionals and education and caring professionals, in order to examine the reasoning behind the answers to the questionnaire and to explore the subject in greater depth. An examination of the data using a word tree generator (Figure 3.5, below) showed that the 10 most frequently occurring words relate to education, eating and eating habits, family and online. Table 3.12, below, lists the ten most frequently occurring words, excluding common words that do not add value to the analysis, such as "example", "think" and similar words.

Figure 3.5. Most frequently occurring words in the Focus Groups

Thematic analysis of the qualitative data revealed four overarching themes: Professionals' Experiences with EDs, Failures in Systems and Training, Family, Friends and Significant Others, and Education. In the analysis, below, for ease of refence and to protect their anonymity, participants will be referred to by an acronym for the focus group they participated in, and given a random participant number. Hence the focus group held with medical professionals will be referred to as FG.Med, the focus group held with Food and Sport Professionals will be referred to as FG.FSp, the focus group held with Mental Health Professionals will be referred to as FG.MH, and the focus group held with Educators and Caring Professionals will be referred to as FG.EdC.

Table 3.12 – The Ten Most Frequently-occurring Words in the Qualitative Data

Frequency	Word	Focus
1	school	Education
2	parents	Family
3	eating	Eating
4	children	Family
5	heathy	Eating
6	food	Eating
7	teachers	Education
8	teacher	Education
9	students	Education
10	online	Online

3.2.1 Professionals' Experiences with EDs

Like the questionnaire, the qualitative data revealed almost all of the professionals who participated, have at some point or other in their professional practice encountered eating disorders, even those who are relatively at the start of their career. It is surprising that across a while variety of fields of practice most professionals have had encounters with eating disorders, indicting a possibility that these disorders are more widespread than we know. The majority of the professionals who participated in the focus groups are not mental health professionals, which underscores the importance of training a wide range of professionals, even those who would not normally be expected to be in a diagnostic position. In reality a professional from any field of practice could be in a position to pin point an eating disorder in a patient, student or client.

> I *have come across eating disorders in different fields … in elderly care and in mental health and disability. I came across bulimia on one occasion, but never anorexia. Most of the time it is binge eating. Most of the time overeating is the issue, not undereating in these type of residents. But it is still bad.*
> *FG.Med_P1*

> *I've had patients who have anorexia nervosa or ARFID.*
> *FG.FSp_P5*

> *Working with the queer community through MGRM [Malta Gay Rights Movement] … it came up as a massive issue within - at that time - among transwomen, trans girls. So that was something that kept coming up.*
> *FG.MH_P1*

> *In our area, at my school I think when we are talking about eating disorders, I see it more on the side of obesity.*
> *FG.EdC_P1*

My community at school is an international community, and it actually verges on the other end – losing weight. We do not experience obesity in our school children, but we had two students who we actually referred [to an institution], because it was a significant level of eating disorder.
FG.EdC_P2

I rarely got clients who have an eating disorder.
FG.MH_P2

Besides coming into contact with EDs in a professional capacity, some participants stated that they had also been contacted in a personal capacity by family and friends seeking direction or advice about their eating habits and suspected eating disorders, or that they personally knew people in their lives who had had an eating disorder.

Not only clients, even people in my social life, there are people who know that I work at Dar Kenn għal Saħħtek, and they approach me. They tell me "I have this problem, what can I do?"
FG.FSp_P4

Apart from having met patients during my work, also, I had one of my best friends, when I was in secondary school, who really had an eating disorder.
FG.MH_P3

Knowledge of eating disorders among professionals is good, Participants demonstrated an awareness of the different disorders, as well as triggers of eating disorders. However, similarly to the questionnaire, ARFID came up several times as a disorder about which little is known. Participants asked several questions about ARFD, with a number of participants expressing a desire for more information and training about this disorder.

The impact it has on the youth today, even with Instagram and all that, it is not being taken into account.
FG.Med_P2

If we were to mention gymnastics or synchronized swimming for example, such athletes may be more predisposed to an eating disorder.
FG.FSp_P1

Sometimes I notice from a person's routine, such as doing a lot of physical exercise, or not doing much exercise, and for example spending a lot of time sitting down.
FG.FSp_P4

There should be more awareness of ARFID, as we think that they are just fussy or spoilt or we blame the parents, but if there is a psychological cause, they need their nutrients. They are still growing. And it has bad ramifications for the public sector and for the economy because the diabetes level keeps on going up.
FG.Med_P2

ARFID was brought to my attention by one of my colleagues because there was a conference on it. And it is something that we want to look into, because we do experience it and we have little awareness of it.
FG.EdC_P2

When asked how they came about their knowledge of eating disorders, most participants stated that there was little specific teaching about EDs in their professional training and that for the most part they took it upon themselves to improve their knowledge. Several participants added that they feel their knowledge is incomplete, and they would like to know more.

In nursing we had a credit about nutrition Eating disorders was a small part, because it was focused on nutrition. Unless a particular love is developed for the topic, or it is used for a topic for the dissertation, it will end there basically.
FG.Med_P1

In psychiatry we had some information and knowledge about eating disorders. But to be honest I did not have much opportunity to develop around that. So really, I would assume I know the basic facts, you know, but nothing in depth.
FG.MH_P2

A concern that emerged rather strongly is that, despite having had contact with the subject, most professionals, from all the fields we examined, do not feel empowered to guide eating disorder sufferers. Although they do their best and even feel a sense of responsibility, they are often left feeling helpless, frustrated and insecure about how to best assist a suspected sufferer.

I would turn to my seniors and reach out for the best way to approach them, because I don't want to be too insensitive. I don't have enough training yet, so I wouldn't feel confident.
FG.Med_P2

But I don't feel comfortable saying: "It's an eating disorder".
FG.EdC_P4

But it's dangerous! For example, I'm speaking as a teacher, I can't really pin-point or label. So, you have to wait, walk on egg shells, and wait to see how it develops. I'm afraid to talk, it's true. It's something that I don't feel comfortable in dealing with.
FG.EdC_P3

Yes, in my case as a Head of School I feel responsible for it. … You have to very delicate in the way you tell them these things, but I feel responsible for it.
FG.EdC_P1

With better eating disorder knowledge, professionals would feel more confident confronting situations of suspected EDs. These situations are always going to be challenging, particularly as there is the possibility that the issue is not an ED, but has similar symptoms. With access to information, knowledge and especially training about how to approach these situations, it is highly likely that professionals from all fields will realise that they have a part to play in

assisting persons with emergent eating disorders, and will feel confident enough to step up to the role.

3.2.2 Failures in Systems and Training

A topic that also emerged repeatedly in the focus group discussion is the subject of failures in systems and training. Besides a lack of training at formative level, and a dearth of continuing professional development (CPD) courses that deal with eating disorders, current systems tend to view EDs as conditions that can only be tackled by professionals from the ED field. However, as evidenced by the data, there is a clear realisation among professionals from all areas of practice that these can be identified by professionals in any profession and then referred to the professionals who specifically diagnose and treat EDs. Unfortunately, for most professions, what little content about eating disorders is included in their formative training is often scant and compartmentalised, which presents a limited picture of these disorders that are complex and multifaceted. However, this does not do justice to the sufferer, as persons with eating disorders often go for years before they are diagnosed.

> *Sometimes it is taken from only one aspect – medical or psychological. But it needs to be taken as a multidisciplinary approach. Also, in the medical degree, we did discuss it, but we went through it like a classification system: science, symptoms, management... so it was very brief.*
> *FG.Med_P2*

> *Even for us, to have more knowledge of certain diseases is needed. We learn through reading, through research, or through discussing with other professionals. I mean we still have to learn a lot of things.*
> *FG.FSp_P5*

> *In the course per se, it wasn't actually addressed in any particular detail. Even within CPD seminars, I don't think I have come across any particular courses, you know.*
> *FG.MH_P2*

> *This idea of orthorexia... I don't know, how legitimate that is? I mean it is not in the DSM, as far as I know. Is this an eating disorder, or is it another kind of ethical choice-making going on?*
> *FG.Mh_P1*

As well as asking for a more holistic approach, participants mentioned that they would like to have more inter-profession collaboration. Effective teamwork eases the burden of taking responsibility in an area that they do not feel well trained in, provides the potential to go beyond customary thinking and the opportunity to gain wisdom from others through the pooling of knowledge and benefits the patient through, among other attributes, better all-round and streamlined care (Green & Johnson, 2015).

> *I really wish that we would work more together. We are not working separately. But it does not make sense that over here we work with a particular strategy, and then over there, we go there and have another strategy.*
> *FG.FSp_P5*

Eating disorders needs to be taken as a multidisciplinary approach.
FG.Med_P2

And I had even brought a psychotherapist into the [skin] clinic, so that they could come in without showing what therapy they were coming in for. I got some clients to book in and have the sessions, but most of them would just say: 'I am just talking to you. Because I want to cure my skin condition"
FG.FSp_P3

However, possibly, the greatest criticism expressed by participants was for failures in systems and organisations. Disappointment was expressed at family cultures that perpetuate harmful habits and ideals, as well as towards cultural practices that maintain and even encourage unhealthy eating habits. A number of comments were also reserved for the conventions that are followed in care and treatment and that are not always updated to reflect changes in thinking or procedures.

In residential care nutritional assessment is needed at least every three months, to see who is gaining a lot of weight or losing a lot of weight. Once an eating disorder is identified in residential care it is harder for sufferers to get the necessary help, as the professional will not be present there and then. Eating disorders are also hard to identify in an acute setting.
FG.Med_P1

We have had a case [in acute care] where the service user had gone to the health centre first, which means that they would have spoken to doctors. So, there is a need across professions, especially those who work in healthcare, that they would at least know and recognize the basics where eating disorders are concerned.
FG.FSp_P4

Our ward is not built for them, we have several people with several illnesses, all together. We had one patient, she came for two, three times... we gave her chicken and some vegetables. We'd go to see that she is eating, but then we got to know that she was keeping all the food in her handbag. We are not trained to cope with these kinds of patients.
FG.MH_P3

Failures in culture and lifestyle which impact not only individuals, but whole systems. Family and community also came under the spotlight. Families, even loving ones, may not always take decisions that are beneficial. They can be in denial and deprive sufferers of much needed care, perpetuate thin-ideal or over indulgence, or simply fall short through lack of guidance and attention to what is going on in the lives of young people and adolescents.

Even the way in which we speak about our bodies, and what we suggest to other people. These are things which children, especially teenagers, pick up a lot.
FG.FSp_P4

With regards to these diets, what message they are giving to kids and to teenagers? A lot of teenagers, and even kids, get affected, because these messages start coming from when they are young.
FG.FSp_P2

I used to find that there were a lot of bad lifestyle, the home lifestyle – very rushed, not finding parents at home when they return, no meals ready, picking their meals out of the freezer, eating on the go...
FG.FSp_P3

However bad eating habits are not only perpetuated within families. Cultural outlook can also be responsible for preserving and propagating unhealthy choices. In Malta a dysfunctional relationship to food is also supported by restaurants that serve children unhealthy food or unnecessarily large portions, our 'easy-pastizzi' mindset, where it easier and cheaper to buy unhealthy, oily food which is available on every corner rather than fresh fruit and vegetables that are expensive compared to other European countries (European Commission, 2019).

In each corner, you find a pastizzi outlet, so it is easy to stop and buy a pastizz or a sausage roll, so these things are tempting. It its business. Even the tuck shops – the Heads of Schools have their hands tied regarding what commands they can give to the tuck shops on what they can sell. So, who is regulating this? Who is regulating these issues? ... We have this culture of the pastizzi, but we need to teach our children from a young age – both physical exercise and positive eating habits. Because we have seen children who, for example, have never seen a kiwi. So how much exposure do children have? I think we need a whole national campaign on this – health eating and the benefits of physical activity. We need to instil it and make it a part of our life.
FG.FSp_P2

I often work with migrant families who have difficult social and financial backgrounds. They often end up for example, for lunch or as dinner, it's cheaper to buy 5 pizzas from the local pastizzi shop, instead of cooking a healthy dinner with vegetables and meat.
FG.EdC_P4

About the restaurants, the variety has to increase, especially in the kids' menu. Not just pizza, burgers, mozzarella, sausages, chicken nuggets... they just serve these things.
FG.FSp_P5

And about the doughnut vans just outside the school, and the ice-cream vans in summer...
FG.FSp_P6

Teenagers and even children, today their lifestyle is very sedentary. And before they make dietary changes, they can start by being more active. Apart from that, how one views exercise is also important. People look at exercise only to lose weight, when in reality exercise has a lot of benefits.
FG.FSp_P4

These type of failures are not only the province of the family, school or community, however. Participants pointed out that these failings are also entrenched in our systems and policies. When you have a mentality that sports is an extracurricular or second-tier subject, this is also doing a disservice to our young people, especially when the mental health-benefits of sporting activities in an increasingly rushed and complex world are now widely recognised (Street et al., 2007). Policies and good intentions, it was pointed out, are not enough – they need to be acted upon.

> *I know the government is already implementing initiatives; more sports activities, there's more open spaces, more sports facilities that are open, programmes... there's a programme on obesity I believe, a campaign. But there needs to be a focus on it, in my opinion.*
> *FG.EdC_P2*

> *As a country we have a problem, for example, with obesity. So, more information and awareness on the subject would definitely benefit everyone.*
> *FG.EdC_P4*

> *We bring out policies, they would be good. I am not saying I am against policies, whatsoever. My problem is with following up, with the actual implementation of the policies. We need to instil it, and make it a part of our life. The subject of PE is treated as a non–recognized subject. As a culture we are still backwards when it comes to recognizing the benefits of activity, the benefit of sports. But unfortunately, the problem is even in the policy - subjects which some children excel in, who are not academically bright, such as Art, physical activity... those we put them aside. How do we change our culture? And sport? We are not talking about elite sports here, we are talking about educating people to be physically active, because yes, PE is recognized as a subject where it can contribute to public health. We are talking about public health, so are we giving it importance or not? Even the new schools, they are all being built without a gym.*
> *FG.FSp_P2*

Participants had strong opinions about topics where they feel that there is significant room for improvement. One such area is training, both formative training and CPD courses, which are seen as lacking, and in the case of the latter, practically non-existent. Practices that maintain unhealthy habits within the family as well as culturally also need tackling in order to bring about a cultural shift that will give prominence to healthy eating habits, the serving of healthy foods and sensible portions in restaurants, and a sports-mindset that are all lacking in our country.

3.2.3 Family, Friends and Significant Others

Family is seen as central in the transmission of values between generations (Min et al., 2012), and this includes healthy feeding choices and attitudes to food. Family, friends and significant others can have a huge influence on persons experiencing eating disorders. They help by providing support and often are a key element in assisting the person towards diagnosis and treatment. Conversely, however, an unsupportive family, or one with

a different outlook, can hinder sufferers by dissuading them from seeking help, maintaining their state of denial, or pushing them towards what they feel is a healthy lifestyle but which may essentially be harmful. Family is also the learning ground for how to eat and what food choices to make (Scaglioni et al., 2018), with "family meals represent[ing] the key sociocultural setting" (Scaglioni et al., 2018, p.6). If children do not learn balance at a young age, it is much harder for them to learn once bad habits are ingrained (Yaşaroğlu, 2016). Focus group participants shared their experiences of both these sides of parental or friend influence.

> *Even by the parents, they might be perpetuating these bad eating habits by shaming them, by trying to be too strict. They give them societal anxiety and depression and this is the issue why family therapy is always recommended.*
> *FG.Med_P2*

> *Then we have parents who might pressure their own children to remain fit, to eat less, and that sometimes is what pushes our young people over the brink.*
> *FG.EdC.P2*

> *Parents give their children large boxes of lunch. Sometimes as much lunch as I give my 24-year old son. We have problems of children who are obese even from the age of three. At our school, we're all the time promoting a healthy life style, promoting sports activities and healthy lunches. We don't allow any unhealthy food in school. But then, what they eat at home, you can't really control that.*
> *FG.EdC_P1*

> *And healthy eating is included in science, and we tackle it as an English comprehension... so they do get the knowledge. But school children often depend on what their parents cook for them or prepare for them. So, the State is promoting health eating, it is teaching about healthy eating. But then as [P1] said, it depends on their parents and on what happens at home.*
> *FG.EdC_P3*

> *Its ok, but it's a conversation you need to have with the parent, to educate them. Sometimes they're in the dark. They don't even have a clue that it could lead to heart problems or issues. I experience it from a cultural point of view. We have a particular community in our school, they send a lot of oily food to school. So, we have to have conversation with them to teach them to send healthy food.*
> *FG.EdC_P2*

> *We also find resistance from the family's side, or else the family influences the service user. The service user would know that they have a problem, but the family would not want to accept that there is a problem. And then the family influences the service user, so that the service user then starts thinking that they do not actually have a problem. Even if the family wants to take out their son or daughter from Dar Kenn ghal Sahhtek, we don't always agree. We would tell them that we don't agree, and we would tell them what the consequences are, but after all it is up to them. Family, friends and significant others have a key role to play in the lives of ED sufferers, and this should be acknowledged. And they also ought to be supported along the ED recovery journey, as this takes a toll even on family.*
> *FG.FSp_P4*

Family and friends as an important partner on the journey towards better health or even diagnosis and treatment. Research shows that the recovery process is heavily influenced by the support that individuals get from the people in their lives (Johns et al., 2019; Linville et al., 2012), and indeed persons who recovered from EDs often report that supportive personal relationships were what motivated them to seek treatment (Linville et al., 2012).

> *I had instances where their own friends come to tell me, "Look she is throwing her lunch in the toilet and flushing it down", for example or I get to know that a coach is weighing them before and after training.*
> *FG.FSp_P1*

> *We have had some cases in the past three years. There were two or three, where the actual peers spoke up. They came and told us that they are very worried about a friend who was not eating at all, who was going for hours without eating, and she was sharing this with them.*
> *FG.EdC_P2*

> *She was getting out of the class literally to go out and vomit during the lectures, and her friends, her close friends, spoke to us and that got our attention to it.*
> *FG.FSp_P2*

> *I also had another case of an athlete I have worked with and his partner went to Dar Kenn għal Saħħtek [to be treated for an eating disorder]. And he needed support, to see how he could support her further. So, that is also a different perspective, that we need to take note of: how best to give support to significant others.*
> *FG.FSp_P1*

Family, friends and significant others play an important role in the lives of ED sufferers. A supportive family is a crucial element of ED recovery, while one that is not supportive or that encourages dysfunctional or flawed habits, for example by encouraging food restraint or over indulgence, could actually be a liability. Family is the first environment where the foundations for life habits are laid and is, for better or worse, an important influence that needs to be considered in any drive for cultural change or ED awareness campaign.

3.2.4 Education

The other environment where children and young persons spend much of their time, and which has an enormous influence on the formation of habits and relationships is school. Alongside imparting knowledge, schools are also centres of influence. Participants across all four focus groups emphasised the importance that educational institutions can have in bringing about a much-needed cultural change. Moreover, teachers are excellently well placed to notice that something is wrong with a child. Children bond with their teachers and open up to them, and since they see the child every day they can notice small changes over time, as well as large ones, more readily than the parents do.

These children sometimes open up to us in a way where you have to do something. Children trust us. The teacher is the link between the two [parents and Senior Management Team (SMT)]. I think if the parents need to be addressed, the teacher should be present as she spends more time with the child than the SMT.
FG.EdC_P3

Maybe we are reachable. I mean usually PE teachers are known to be role models to students, they feel comfortable to talk to us. From my experience as a teacher in a school, I used to realize immediately when a child had a problem. So that, if there is something, if we really know the children, we pick it up. Because as teachers we are the carers of children, we can pinpoint that there is something wrong.
FG.FSp_P2

Schools and educational institutions are also, of course, important vehicles for learning. As well as being channels for the dissemination of knowledge and formation of habits, schools can expand on family influence by supporting children's perceptions, enhancing knowledge and developing their understanding of social interactions (Maldonado-Carreño & Votruba-Drzal, 2011). Subjects such as home economics and PSCD are useful in teaching life lessons that can remain with the child throughout the life course, and would be a good choice for teaching healthy food habits, cultivating self-esteem and combating the detrimental body-image influences of social media.

I used to have a food pyramid chart which I used to take out and show to my clients. And, unless they would have chosen Home Economics at school, very few teenagers were aware of it. My own daughter chose Home Economics and I realized that it is a subject that should be compulsory to all students, because there is so much knowledge about everyday life which could really help them. Regarding knowledge, something that my daughter learnt in Home Economics which was really useful, and which then she taught all of us, was reading food labels, so that where anything is high in sugar, or high in salt, you will realize. So, they started reading crisp packets, biscuit packets. And they realized that all the snacks that are 'reward' foods are actually very unhealthy. This is really helpful in helping people make better choices.
FG.FSp_P3

I'm sure that there should be education for boys as well, especially for obesity to be fair, rather than for anorexia.
FG.MH_P2

Healthy eating could be part of the PSCD lessons, which are not done by the class teacher who has a whole lot of other things to teach, so it would fit more in this curriculum.
FG.Med_P1

We need to create a bigger awareness with educators. Educators need to be educated in how to deal with this body image issue, especially P.E teachers. You find children that do not want to do P.E because they are self-conscious. I think educators within schools, and not just the specialists, need to be given some kind of support, the tools for how to go about dealing with these issues.
FG.FSp_P2

Schools strive very hard to teach good habits, promote health eating and exercise. However, sometimes parents are not cooperative, or bad habits prove hard to kill. Participants emphasized the importance of not sending mixed messages, for example by promoting health eating but then having a hot dog day in school; as well as educating parents who can be resistant to change and may need educating themselves.

> *Before Covid there used to be a lot of events, of healthy week and healthy day, and fruit day, and then we do pizza day and hot dog day... and I mean, I am not against these things, because at the end of the day, it's about the balance. But how are we going to educate children about balance? How are we going to support the children in their self-belief? Because this is all related. We need to see the thing holistically as a package - the message we are giving young people today. Because we know well enough that prevention is better than cure, so how can we strengthen the prevention base, before we arrive at a stage where the children are at a point of no return? FG.FSp_P2*

> *We don't allow any unhealthy food in school. Even if for example someone comes and tells us "Because I didn't have time to do the lunch this morning", and they buy the child a sausage roll. I don't accept it – I tell them, "Better a bread roll". FG.EdC_P1*

> *For breakfast, during breakfast club, sometimes if they offer them a brown bread sandwich, there is a lot of waste, because children opt not to take it. And they spend till 10 o'clock without eating. Or sometimes they offer them a muffin, so I don't think it's the healthiest option. But it is offered in school. Then, if they have their birthday or something like that they can't bring a cake. So, there are contradictions in schools. FG.EdC_P3*

Schools go well beyond teaching and often assist children and families who have difficulties, and do deal with all sorts of issues such as social problems, learning difficulties, and other issues which impact the child or youth under their care. In fact, schools usually have protocols in place to deal with concerns such as inclusion, bullying, and similar issues. With eating disorders, or unhealthy eating habits that could escalate to a disorder, the problem could be that there are no clear systems for dealing with such issues. In fact, this issue was raised by a number of participants, even from non-educational fields, such as triaging patients in critical care and social and youth work, which will be tackled further down. If some type of standard operating procedures (SOPs) were set in place and standardised across areas of professional practice, tacking these problems when they arise would be easier to deal with. As mentioned above, schools are important partners in noticing children's changing habits, and can be especially valuable collaborators in catching these dangerous disorders before they escalate. Unfortunately, however, when it comes to schools, there is no standardised systems and each educational institution has to find its own way and create its own procedure.

> *Usually it's picked up by PE teachers, our counsellors, but even our home room [class/form] teachers. They tend to start noticing signs of students who are not eating their lunches, who are really conscious about their body. So, then they start watching what they are eating. We do run our own investigations when it comes to our attention, but we try to do it in a speedy manner. We drop everything and that case becomes our*

focus for the day. Because in my opinion, and in our protocol at school, the parents need to be informed as soon as possible. So, I try not to delay the time between when we found out and when the parents get to know. Even if I don't have enough substantial evidence whether the child has an eating disorder or has difficulties with their eating patterns, I will still call a meeting [with the parents] and tell them: "Look, these are our suspicions".
FG.EdC_P2

Usually in primary schools it's the class teacher who notices first, then she informs the senior management team. We usually monitor for a few days, then we contact the parents. … It's always difficult. Sometimes even if you just tell them about speech or potty training, they will tell you, "But at home they say everything", or, "At home we don't have this problem". We do get those kinds of parents. But, you have to pin-point, you know. I'm not saying that all parents are like that, these are just the few. But these are the ones that you have to be more persistent with.
FG.EdC_P1

I don't think it's the teacher's or someone from the school's position to tell them such things. … So, what could be the solution? Because teachers are burnt out. The problem is that we are not trained enough. So, what could be done?
FG.EdC_P3

Social workers in education – definitely there are not enough. Sometimes you have one or two social workers per college and they can't even deal with absenteeism, let alone go into eating disorders.
FG.EdC_P4

Yes, I think guidelines will always help. There's a lack of awareness. It's not talked about enough. We're experiencing it in our youngsters, and yet it's something that we explore and kind of have to deal with by ourselves. So absolutely – guidelines, awareness, definitely. It is necessary in my opinion. I'm an independent school who hardly gets access to any of the services. We have to deal with it on our own unfortunately. And I understand that there's only so much that the government can offer. But there are the national student support services, like the anti-bullying services, substance abuse services, inclusion services … maybe one hub could be for eating disorders, whether it's through Dar Kenn għal Saħħtek or through the government.
FG.EdC_P2

Educational establishments, being another environment where children and young people spend much of their time, constitute centres of learning and influence. Since teachers spend so much time with their charges they are in an excellent position to spot changes in their pupils. Additionally, children tend to open up to them in way that they may not do with other professionals or even parents, which makes the school environment a very influential one when it comes to spotting EDs, imparting knowledge and forming good habits. Schools and educators should not be overlooked as valuable collaborators.

3.3 TRAINING AND INFORMATION NEEDS

One of the objectives of this project was to explore how the health sector in collaboration with Dar Kenn għal Saħħtek can respond to these challenges. To this end, focus group participants were also asked about their learning and training needs, and preferred methods of information delivery. All focus group participants replied that they would welcome learning more about eating disorders, with most stating that online short courses would be the most accessible form of delivery. Participants also mentioned e desire to contribute in highlighting and helping with these cases and expressed their belief that more awareness is needed among the general public, as well as among professionals.

> *There needs to be more awareness of how many problems there are with eating disorders. There isn't a lot of awareness. We are conscious of obesity yes. But what about eating disorders? How much public awareness is there? And that we have problems of eating disorders? Or even awareness of eating disorders in boys? Because we normally see it in girls, because of body awareness, body image, but for sure it exists in boys. But are we creating awareness? Are they aware that their children are going through this phase of adolescence, that they are growing, where they want to look good, muscles and all that?*
> *FG.FSP_P2*

> *Participants also expressed concern about wanting to do their best in these situations, their nervousness about not having the right language and not wanting to make the situation worse. One of the participants, who works in the field of eating disorder recovery and has experience with the fluctuating nature of recovery, had some valuable advice to give:*

> *Basically, whatever tools you have, you can give to the person, whether it is a link, or a telephone number – if that is all you have, that can be enough for the person to make contact when they feel that they are ready. And then, it is up to him or her.*
> *FG.FSp_P4*

This is important advice, as it highlights that the professional is not an expert in the field and cannot take full responsibility for the recovery of the person. They can give them all the necessary tools to refer them forward or make contact with recovery programmes, but the sufferer then needs to take the steps themselves. It is important to acknowledge that if they are not ready, they may not be willing to do so. This is possibly a theme that should be taken into consideration for inclusion in training courses and CPD programmes. Otherwise professionals that come from other fields might feel that the full responsibility for recovery of the potential ED sufferer will fall upon them, and this may make them reluctant to intervene.

In expanding on the necessity for training, many shared their experiences regarding areas of professional practice that would surely benefit from ED awareness and training. Areas mentioned include emergency department staff, who are at the forefront of hospital and emergency admissions; public health and youth workers; and educators among others.

> *In addition to first year doctors, I would add emergency department staff, because they are the first in line. So, triage nurses, ambulance staff, doctors in accident and emergency. It would be directed to medical professionals in Accident and Emergency, because they will give the first outline of the diagnosis. When working in Accident*

and Emergency, there is a training programme for professionals working there. For sure this is the case with nursing staff. And this can be one of the topics which is included in that programme, along with fall from heights, cardiac arrest, etc.. another topic would be identifying eating disorders, or awareness.
FG.Med_P1

In public health and youth work, and there is always a big response from youth workers. I mean from students, there is a lot of interest in approaching it [learning about eating disorders]. For example, what are the social impacts of eating disorders? And how does it relate to other problems of body image, and the way they see other people, and see themselves represented in the media for example? So, I feel that is what people want to have conversations about.
FG.MH_P1

These testimonials suggest targeted eating disorder training courses that should be tailored to the interests and needs of the different groups the course will be addressing. Participants also expressed an interest in learning about the manifestation of eating disorders in their particular fields. The literature, for example, states that signs to look for in the class room include sudden changes in disposition, deteriorating grades, attempts to cover the body by wearing clothing that is too large, or long sleeves even in hot weather, among others. In residential settings, however, practitioners could look for possibilities that the sufferer is stowing food away rather than eating it, as stated by participant FG.MH_P3, above. Participants also discussed learning methods that they have experienced and found useful, or that they would like to see in courses or training programmes for eating disorder knowledge. Additionally, they emphasised the need to educate the general public.

I believe that training should be offered, even to the educators. And training to the general public. ... We could maybe discuss some cases, maybe how things are being handled in certain cases. There is no need to reveal the details of the patient, just to see the best care that is given to the patient, a platform for learning.
FG.FSp_P5

Perhaps seminars with role play and tips, and speakers that have knowledge in this field. And patients could tell their story - what worked for them and what didn't. Patients telling their story about how they came to their diagnosis. In medicine we already use role play a lot to learn. We pretend we have the patient, in a certain situation. It helps to act it out and to see the protocol, it helps to train in that sense.
FG.Med_P2

And the second thing for the training , I guess Dar Kenn għal Saħħtek has access to a lot of resident and non-resident patients, and former patients, who have incredible narratives to share. I find, even as professionals, there is nothing better than listening to somebody who has gone through, or has engaged with the issue, to inspire not only people to start reporting, but also for us to work with a human being and not just a list of diagnostic criteria
FG.MH_P1

Work experience abroad would really help. Because sometimes you see how other people do things, and how other cultures tackle things, and this has an impact as well.
FG.FSP_P6

Various possibilities for course delivery were discussed with participants, with the prevailing agreement being that online course would be the most accessible and flexible option. Mention was also made of the possibility of having combinations of types of course, such as online courses that are pre-recorded and can be accessed at a later date or time, or of having hybrid courses where the main sessions are online but one lecture could be in person; which would allow for networking opportunities, as well as the benefit of hearing speakers live, which was described as a powerful learning experience. Having an attendance certificate was mentioned as a baseline for such courses, but when assessing the courses was discussed, participants suggested possibly having the option, for those who wished to take the course further, of obtaining an accreditation by completing an assessment. All participants mentioned that ED courses are not usually provided as CPD courses and expressed great interest in seeing CPD courses dedicated to the subject, for which they were also prepared to pay.

Seminars are a good idea, especially nowadays. I mean you don't have to get out of the house, move the car, find a parking space. For example, I was cooking 5 minutes before this group, so it's very convenient. As long as they are at a convenient time, because in the morning we work. I'm mostly self-employed, so there needs to be some sensitivity towards that, even if it is repeated. For example: the course is going to happen on these different dates and times. Different options, you know, because sometimes there are a number of them, either a whole day, or short and repeated, because then you can still do other things, whether its personal or professional. When it is a whole day, you're out of action for a whole day.
FG.MH_P2

I enjoy listening to pre-recorded material, especially if there is an interactive element, because sometimes your question is everybody else's question anyway. This would be more successful if they take into account that for a lot of us warranted professionals, and I'm sure nurses as well, the CPD hours are a reality. So why can't more of these really important, valuable training be certified as part of that? I think that maybe Dar Kenn ghal Sahhtek etc, all these groups, can look into the fact that we need this [CPD] and there is a relatively narrow market group. There are very few places you can get the CPD hours for now, so why not expand it more? And the certificate of attendance is very important. I know of organizations who offer either just attendance, or else some form of certification, assignments, etc. I think it should be an option. I would love to go to a workshop, and if you find it interesting enough, you can take that extra step and fulfil the assignment, or whatever. If it counts towards CPD yes, the expectation, it is that you will pay for it, whatever it is. I have seen so many different ways of doing it. But what I've seen increasingly are more these micro-kind of CPD, which I guess is more like we are saying, of one afternoon.
FG.MH_P1

I think an online platform perhaps, where one can go to and seek information, and seminars, would be ideal. I have to say, I miss the networking. I miss going for seminars and conferences and meeting colleagues. However, like everyone, I have

very long hours, a very busy schedule, so I don't know where I can fit after school, a conference or hours. A combo would be great.
FG.EdC_P2

...and now with the online option, it's great. You don't have to go after school. And, if you have family it is easier, more manageable. That would be easier, a good option.
FG.EdC_P3

3.4 DISCUSSION

The data collected via questionnaire and focus groups revealed that Maltese professionals have a good knowledge of eating disorders, but that there are certain eating disorders that are less known than others. It also emerged that, overall, participants did not feel confident in their knowledge and expressed a wish for more information, disclosing that their lack of confidence would possibly hinder them in assisting a person they suspect of having an eating disorder.

The questionnaire revealed that although generally knowledge of eating disorders among professionals is good, there is some discrepancy within professions as well as among the different professions, and even between the extent of knowledge for the specific eating disorders. ARFID emerged as the ED that is least understood, while Anorexia, despite being the least prevalent of the eating disorders, is the disorder about which there is most knowledge. Examining the standard deviation of scores for all EDs, it emerged that, except for ARFID, although there are discrepancies in knowledge among persons holding the same profession, these are not very large. However, as regards understanding of AFRID, even within professions there is considerable divergence of knowledge about this disorder. The questionnaire also revealed that mental health professionals have statistically significantly better knowledge of eating disorders than educators, possibly due to the fact that mental health professionals inherently have good mental health literacy, while this is not a requirement in positions in education. Another point to emerge from the questionnaire, is that professional practitioners across the board have had encounters with eating disorders, demonstrating that all professionals may have an important role to play in detecting EDs not just those who are currently in roles that traditionally diagnose EDs. However, as most professionals professed to feeling a lack of confidence around the subject and a desire for further training, it is vital that practitioners are given the tools to be effective collaborators in detecting these disorders in their various settings.

Examination of the qualitative data revealed four overarching themes: Professionals' Experiences with EDs, Failures in Systems and Training, Family, Friends and Significant Others, and Education. Like the questionnaire, the qualitative data revealed almost all participants have at some point or other in their career encountered eating disorders, even those who are relatively at the start of their career. This suggests that possibly the figure of diagnosed EDs is actually lower than real incidence in the population. As the professionals who participated in the focus groups come from a vast array of areas of practice, this underscores the importance of providing training to a wide range of professionals, not just those professions that would customarily be expected to have a diagnostic role. The experiences of the participants in this study show that professionals from any field of practice could be in a position to detect an eating disordered person.

Study participants also indicated that there exist a number of failings in systems and training. Awareness of eating disorders is not given a place in most formative training courses, or at best only makes a cursory appearance. Added to this, there is a complete lack of continuing professional development (CPD) courses that deal with eating disorders. Both these factors form a deep lacuna in the potential for interested professionals to obtain sufficient knowledge of eating disorders. Additionally, there is no content, in any course, that informs professionals about how EDs can manifest in the different areas of practice. These failings in instruction contribute to the length of time that eating disorders tend to remain undetected. The literature tells us that on average, for most sufferers, the gap between onset and diagnosis is 5.3 years (Hamilton et al, 2021). With better training systems, CPD courses and other post-graduate training, it is possible to both improve the ED knowledge of professionals and give them the confidence they currently lack, such that any professional can feel empowered to detect EDs.

Another notable issue that emerged was our sometimes detrimental cultural relationship to food, and lack of pro-sport mentality. Cauchi et al (2015) characterise Malta as having "limited infrastructure for active living combined with an energy-dense food supply" (p.3211). This sentiment that was echoed in the focus groups, where participants observed that Malta's restaurants, food culture and a mentality that does not seem to value or give importance to sports in the curriculum and in daily life were maintaining and even encouraging unhealthy eating habits.

Family emerged as another central theme. Family, a hub where traditions and values are passed down to future generations, is also a major influential in how food is perceived. Family, friends and significant others can both help or hinder persons experiencing eating disorders. In fact, having good support systems in place is an essential ingredient of successful ED recovery, which more often than not, this means family support (Hart et al., 2012). However, if the family or supporting persons are not in concurrence, or hold values that are at odds with the diagnosis or treatment given, they can be a liability. The practises observed within families are also very important – it is much harder for training and education to have a positive impact if they contradict the values practiced within the family. As the environment where the foundations for life habits are laid, family is an important influence that needs to be considered in any drive for cultural change or ED awareness campaign.

Another hugely influential arena is the school environment. Like the family, educational institutions are able to have an enormous influence on the formation of habits, as well as being vital collaborators in bringing about cultural change. Children bond with their teachers and open up to them, while subjects such as home economics and PSCD are useful in teaching healthy habits and life lessons, as well as teaching young people how to safely navigate contentious issues in social media, such as think-thin culture, body image and self-esteem. Yet, although school can be a vital playing ground in cultivating healthy practices and imparting knowledge that can fortify young people against some of the triggers of eating disorders, teachers and educators are not given instruction on the subject, and often have no procedures in place for tackling these difficult issues. The formation of collaborations with schools, the provision of instruction and courses targeted at educational institutions, and assistance in creating protocols for handling suspected cases of EDs, would enlist the assistance of these crucial collaborators in taking action against eating disorders.

Finally, enquiring about the education and information needs of professional practitioners in Malta showed that the vast majority would welcome further instruction, especially in the form of CPD courses, as currently there are no such courses being offered. Participants expressed a preference for online courses, although a hybrid format that would allow for some physical interaction would also be welcome.

This study has shown that there is a need as well as a request from professionals from various fields to learn more about eating disorders. While certain professions, such as doctors or psychiatrists, are typically seen as being better placed to diagnose EDs, the data explored in this study confirms that any professional that comes into contact with clients, students or patients, or has any human contact, can help potential sufferers. These professionals can recognise potential ED sufferers and point them in the direction of a clinical diagnosis, and ultimately treatment and recovery. It is hoped that this will help to cut short the time sufferers spend living with an eating disorder and ensure a better outcome for the person.

Chapter 4
Conclusions and Recommendations

4.1 CONCLUSION

This research project set out to explore the eating disorder information and training needs of various professionals in Malta, who although may not work directly in the field of eating disorders, may be in a position to recognise the presence of a possible eating disorder in the students, clients or patients that they come into contact with. Research shows that eating disorders may take years to be diagnosed, yet the sooner they are diagnosed and the person engages in treatment, the better the chances of recovery (Maguire et al., 2019; Schaumberg et al., 2017; Worsfold & Sheffield, 2019).

This study has revealed that professionals from a variety of fields do come into contact with eating disorders, and that overall their knowledge of eating disorders is good. There is however, some discrepancy in eating disorder knowledge between different professions, as well as in the extent of knowledge of the specific eating disorders. Participants were generally found to be least knowledgeable about ARFID (Avoidant/Restrictive Food Intake Disorder). Mental health professionals were found to have statistically significantly better knowledge of eating disorders than educators; possibly due to the fact that mental health literacy is integral to the mental health professions, but not to education professions. In line with the findings of Evans et al., (2011) and Worsfold & Sheffield, (2021), this study also discovered that professionals do not feel empowered to speak to suspected sufferers about eating disorders, as they feel that they are not knowledgeable enough and fear that instead of helping, they will make things worse. Indeed, the majority of study participants expressed a clear desire for more training and information about eating disorders.

Figure 4.1. Table of Findings

Finding	***Data***
Questionnaire	
Professionals from a wide range of profession have good knowledge of eating disorders.	*Mean score (out of 40) for overall knowledge of eating disorders was 29.74.*
Most questionnaire respondents have had experiences with persons having an eating disorder.	75% (n=92) of respondents stated that they have encountered clients with eating disorders in the course of their professional practice.
Most professionals would find it difficult to approach a potential ED suffer to speak to them about their suspicions.	When asked whether they would, 70% of respondents reported that they would find it difficult to inform clients if they thought that they had an eating disorder, (21.1% = difficult; 48% = moderately difficult).
Professionals practicing in Malta would like to know more about eating disorders.	89% (n=109) of respondents claimed that they would like to have more information and/or training about eating disorders.
Focus Groups	
Most practitioners have had encounters with EDs, even those who are relatively at the start of their career.	I have come across eating disorders in different fields … in elderly care and in mental health and disability. FG.Med_P1 Yes, we had patients who had eating disorders. One of them, she did spend some time there with us, and she did come for several times. FG.MH_P3
Although generally ED knowledge is good, similarly to the questionnaire, ARFID came up several times as a disorder about which little is known and about which more information and training would be welcome.	ARFID was brought to my attention by one of my colleagues because there was a conference on it. And it is something that we want to look into, because we do experience it and we have little awareness of it. FG.EdC_P2
There is very little formative training about eating disorders, most practitioners have to research the subject themselves.	I discuss with the dietician from Dar Kenn għal Saħħtek, and even with the nurse, and I do some research for information. Other than that, I didn't receive any specialized training and education regarding eating disorders. *FG.FSp_P5*
Most professionals expressed a lack of confidence relating to the subject and do not feel empowered to guide eating disorder	I would turn to my seniors and reach out for the best way to approach them, because I don't want to be too insensitive. I don't have enough

4.2.1 Recommendations for Policy and Practice

- Offer training courses targeted at various professional groups, such as schools and educators, mental health professionals, medical professionals, social, youth and community workers, etc.
- Offer general as well as CPD courses, either through Dar Kenn għal Saħħtek, or in collaboration with other institutions.
- Hold discussion with stakeholders at the University of Malta and other vocational training institutions to increase the coverage of eating disorders in relevant undergraduate and vocational courses (such as education, social work, sports professions, etc), in order to improve early detection of eating disorders; with special attention to courses for the medical and mental health professions, as these professionals are the ones that traditionally have a diagnostic role.
- Work with partners and stakeholder to create an eating disorder prevention programme.
- Lobby government, MHRA (Malta Hotels and Restaurants Association), and other stakeholders in order to create systems that promote heathy food choices, for example, tax subsidies on fruit and vegetables, the inclusion of healthy children's meals on menus, taxing unhealthy food, etc.
- Lobby the education department and other stakeholder for greater inclusion of sports on the curriculum, more sports facilities in school and greater general awareness of the health benefits of sports.
- Collaborate with stakeholders from various professions to set up standardised SOPs across areas of practice in order to facilitate recognition of EDs and onward referral of sufferers by professional practitioners.
- Lobby stakeholders in media for more coverage of eating disorder topics in all areas, including but not limited to, news and discussion programmes, creation of ED storylines in dramatic content and fiction, series, etc; to diversify information communication to passive learning routes.
- Lobby for the inclusion of a labelling system such as traffic light system on locally produced food stuffs, to indicate the levels of substances such as fat, sugar, salt and artificial flavourings, for better recognition of unhealthy foodstuffs among the general public.
- Create an information system, such as a tab on Dar Kenn għal Saħħtek's Facebook page or similar, with information about what to do if a person suspects that someone they know may have an eating disorder, in order to counteract fear of phrasing interventions wrongly, that may dissuade individuals from helping others they suspect may have an ED.
- Collaborate with schools at primary, secondary and post-secondary level, to create awareness of issues leading to eating disorders or dysfunctional eating habits, such as body image, the ways in which social media content can influence young people, and similar issues.

- Undertake a public awareness campaign via different media, in order to raise the general awareness of eating disorders in the population.
- Address issues of stigma and eating disorders, by undertaking initiatives to tackle idealised and impossible body standards for all genders and ages, normalising conversations around the topic and encourage sufferers to share their experiences, among others.

4.2.2. Recommendations for Research

- Engage in research to examine best practices and interventions in creating eating disorder prevention programmes.
- Undertake research to develop SOPs for different professions and provide a list of the salient characteristics in which EDs manifest in particular areas, to facilitate recognition of EDs in various settings.
- Research the prevalence of ARFID in the population, as well as the general preparedness of professionals and services.
- Investigate overeating and obesity in Malta, its causes and epidemiology, and take action to reduce Malta's position as one of the European countries with the highest prevalence of obesity.
- Replicate the 2020 study 'The Prevalence of Eating Disorders in Youths Aged 10 to 16 Years', carried out by the Faculty for Social Wellbeing, every 3 to 5 years, in order to establish longitudinal prevalence and monitor trends.
- Engage in a study of eating disorders among communities such as LGBT+ and migrants, in order to better cater for these demographics that may be overlooked by traditional screening methods.

4.3. CONCLUDING NOTE

This study has examined the requirements of professional practitioners for knowledge and training of eating disorders and made a number of recommendations for research, policy and practice. The implementation of the proposed recommendations provides a starting point for dealing with the gaps in knowledge and confidence reported by study participants. Enhancing the eating disorder literacy and knowledge of professionals from all fields will enlist their assistance in recognising these disorders in the persons they come into contact with in their professional practice. The provision of training, CPD courses and better understanding of eating disorders in their various contexts, will empower professionals to assist sufferers and help decrease the gap between onset of an eating disorder and the start of treatment. This has been shown to be vital in enhancing the prospects of suffers and improving recovery (Schaumberg et al., 2017).

Eating disorders may not be highly prevalent in our communities, however when they do strike, they truly devastate the lives of sufferers and the people close to them. It is the hope of the research team, through this study, to improve the situation locally for sufferers and their families. Fostering better collaboration between all professions and enlisting the help of practitioners is crucial in effectively tacking eating disorders on our shores and improving the outlook for ED sufferers in Malta.

REFERENCES

Agius, Marie Claire. (2015). The Maltese Psychologists' Lived Experience of Working with Eating Disorders. [Bachelors dissertation, University of Malta]. https://www.um.edu.mt/library/oar/handle/123456789/5902

Ali, K., Farrer, L., Fassnacht, D. B., Gulliver, A., Bauer, S., & Griffiths, K. M. (2017). Perceived barriers and facilitators towards help-seeking for eating disorders: A systematic review. International Journal of Eating Disorders, 50, 9–21. doi:10.1002/eat.22598

APA - American Psychiatric Association. (2021, March). What are eating disorders? https://www.psychiatry.org/patients-families/eating-disorders/what-are-eating-disorders

APA, 2013. Diagnostic and Statistical Manual of Mental Disorders. 5th Edition. Washington DC: APA.

Barthet, Thea. (2013). Exploring the Level of Awareness regarding Eating Disorders amongst Home Economics Teachers in Malta and Gozo. (Bachelors dissertation, University of Malta). https://www.um.edu.mt/library/oar/bitstream/123456789/8636/1/13BED022.pdf

Bratland-Sanda, S., & Sundgot-Borgen, J. (2013). Eating disorders in athletes: overview of prevalence, risk factors and recommendations for prevention and treatment. European journal of sport science, 13(5), 499-508. https://www.tandfonline.com/doi/pdf/10.1080/17461391.2012.740504?needAccess=true

Buchholz, L. J., King, P. R., & Wray, L. O. (2017). Identification and management of eating disorders in integrated primary care: recommendations for psychologists in integrated care settings. Journal of clinical psychology in medical settings, 24(2), 163-177. DOI 10.1007/s10880-017-9497-8

Bullivant, B., Denham, A. R., Stephens, C., Olson, R. E., Mitchison, D., Gill, T., Maguire, S., Latner J.D., Hay, P., Rodgers B., Stevenson R.J., Touyz S. & Mond, J. M. (2019). Elucidating knowledge and beliefs about obesity and eating disorders among key stakeholders: paving the way for an integrated approach to health promotion. BMC public health, 19(1), 1-10. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-7971-y

Cauchi, D., Rutter, H., & Knai, C. (2015). An obesogenic island in the Mediterranean: mapping potential drivers of obesity in Malta. Public health nutrition, 18(17), 3211-3223. https://doi.org/10.1017/S1368980015000476

Cain, B., Buck, K., Fuller-Tyszkiewicz, M., & Krug, I. (2017). Australian healthcare professionals' knowledge of and attitudes toward binge eating disorder. Frontiers in psychology, 8, 1291. Doi: 10.3389/fpsyg.2017.01291

Camilleri, S. (2007). Eating disorders : the need for a residential centre in Malta and the role of the social worker within it. [Unpublished Bachelors dissertation, University of Malta].

Cena, H., Barthels, F., Cuzzolaro, M., Bratman, S., Brytek-Matera, A., Dunn, T., Varga, M., Missbach, B. & Donini, L.M. (2019). Definition and diagnostic criteria for orthorexia nervosa: a narrative review of the literature. Eat Weight Disord 24, 209–246. DOI: 10.1007/s40519-018-0606-y

Chally, P.S. (1998), An Eating Disorders Prevention Program. Journal of Child and Adolescent Psychiatric Nursing, 11: 51-60. doi:10.1111/j.1744-6171.1998.tb00431.x

Chetcuti, Kym. (2020). Perceptions of Orthorexia Nervosa amongst Health Care Professionals. (Bachelors dissertation, University of Malta). https://www.um.edu.mt/library/oar/bitstream/123456789/72348/1/20BPSY032.pdf.pdf

Currin, L., Waller, G. & Schmidt, U. (2009). Primary Care Physicians' Knowledge of and Attitudes Toward the Eating Disorders: Do They Affect Clinical Actions? The International journal of eating disorders. 42(5): 453-458. DOI: 10.1002/eat.20636

Ebneter, D. S., & Latner, J. D. (2013). Stigmatizing attitudes differ across mental health disorders: a comparison of stigma across eating disorders, obesity, and major depressive disorder. The Journal of nervous and mental disease, 201(4), 281-285. DOI: 10.1097/NMD.0b013e318288e23f

Esposito S. (2008). The malteser with an eating disorder : a study of the experience of general practitioners with cases of eating disorders. (Diploma Thesis, University of Mata). https://www.um.edu.mt/library/oar/bitstream/123456789/4704/1/08YTH010.pdf

European Commission – Eurostat (2019) Comparative Price Levels for Food, Beverages and Tobacco – Statistics Explained. https://ec.europa.eu/eurostat/statistics explained/index.php/Comparative_price_levels_for_food,_beverages_and_tobacco#Price_levels_for_oils_and_fats.2C_fruits.2C_vegetables.2C_potatoes_and_other_food_products

Evans, E. J., Hay, P. J., Mond, J., Paxton, S. J., Quirk, F., Rodgers, B., ... & Sawoniewska, M. A. (2011). Barriers to help-seeking in young women with eating disorders: a qualitative exploration in a longitudinal

community survey. Eating Disorders, 19(3), 270-285. https://doi.org/10.1080/10640266.2011.566152

Falzon Aquilina, F., Grech, A., Zerafa, D., Agius, M., & Voon, V. (2015). 'Dar Kenn Ghal Sahhtek' - an eating disorder and obesity service in Malta. Psychiatria Danubina, 27(1), 526-529. DOI: 10.1016/j.eurpsy.2016.01.1548

Farrugia, D. (2004). Eating disorders: the role of the school social worker. [Unpublished Bachelors dissertation, University of Malta].

Green, B. N., & Johnson, C. D. (2015). Interprofessional collaboration in research, education, and clinical practice: working together for a better future. Journal of Chiropractic Education, 29(1), 1-10. https://doi.org/10.7899/JCE-14-36

Grech, A. (2013). Eating disorders in Malta. Psychiatria Danubina, 25 (Suppl. 2), S256-257. PMID: 23995188

Griffiths, S., Rossell, S. L., Mitchison, D., Murray, S. B., & Mond, J. M. (2018). Pathways into treatment for eating disorders: A quantitative examination of treatment barriers and treatment attitudes. Eating disorders, 26(6), 556-574.] https://doi.org/10.1080/10640266.2018.1518086

Hamilton, A., Mitchison, D., Basten, C., Byrne, S., Goldstein, M., Hay, P., ... & Touyz, S. (2021). Understanding treatment delay: perceived barriers preventing treatment-seeking for eating disorders. Australian & New Zealand Journal of Psychiatry. https://doi.org/10.1177%2F00048674211020102

Hay, P., Darby, A., & Mond, J. (2007). Knowledge and beliefs about bulimia nervosa and its treatment: a comparative study of three disciplines. Journal of Clinical Psychology in Medical Settings, 14(1), 59-68. https://link.springer.com/content/pdf/10.1007/s10880-007-9057-8.pdf

Hellings, B., & Bowles, T. (2007). Understanding and managing eating disorders in the school setting. Australian Journal of Guidance and Counselling, 17(1), 60.

https://www.researchgate.net/publication/236872213_Understanding_and_Managing_Eating_Disorders_in_the_School_Setting

Hopper, J. (2021). Tips on "Reverse Wording" Survey Questions. Versta Research. https://verstaresearch.com/blog/tips-on-reverse-wording-survey-questions/

Jenkins, A. (2005). Identifying eating disorders. British Journal of Nursing 14.19 : 1034-038. http://web.a.ebscohost.com.ejournals.um.edu.mt/ehost/pdfviewer/pdfviewer?vid=1&sid=53598ad0-02dd-4d45-b344-de72c4fbf117%40sdc-v-sessmgr03

Johns, G., Taylor, B., John, A., & Tan, J. (2019). Current eating disorder healthcare services–the perspectives and experiences of individuals with eating disorders, their families and health professionals: systematic review and thematic synthesis. BJPsych Open, 5(4). doi: 10.1192/bjo.2019.48

Johansson, AK., Johansson, A., Nohlert, E. et al. Eating disorders - knowledge, attitudes, management and clinical experience of Norwegian dentists. BMC Oral Health 15, 124 (2015). https://doi.org/10.1186/s12903-015-0114-7

Jones, W., Saeidi, S. & Morgan, J. (2013). Knowledge and Attitudes of Psychiatrists Towards Eating Disorders. European eating disorders review : the journal of the Eating Disorders Association. 21 (1): 84-8. DO - 10.1002/erv.2155

Knightsmith, P., Treasure, J., & Schmidt, U. (2013). Spotting and supporting eating disorders in school: recommendations from school staff. Health education research, 28(6), 1004-1013. https://doi.org/10.1093/her/cyt080

Knightsmith, P., Treasure, J., & Schmidt, U. (2014). We don't know how to help: an online survey of school staff. Child and adolescent mental health, 19(3), 208-214. https://doi.org/10.1111/camh.12039

Levine, M. (2017). Communication challenges within eating disorders: What people say and what individuals hear. In Jauregui-Lebera I. (ed) Eating disorders: A paradigm of the biopsychosocial model of illness, 239-272. InTech Open. DOI: 10.5772/65305.

Linville, D., Brown, T., Sturm, K., & McDougal, T. (2012). Eating disorders and social support: perspectives of recovered individuals. Eating Disorders, 20(3), 216-231. https://doi.org/10.1080/10640266.2012.668480

Lund Research. (2018). One-way ANOVA. https://statistics.laerd.com/statistical-guides/one-way-anova-statistical-guide.php

Maguire, Sarah, Li, Ang, Cunich, Michelle, & Maloney, Danielle. (2019). Evaluating the effectiveness of an evidence-based online training program for health professionals in eating disorders. Journal of Eating Disorders, 7(1), 14. https://doi.org/10.1186/s40337-019-0243-5

Maldonado-Carreño, C., & Votruba-Drzal, E. (2011). Teacher–child relationships and the development of academic and behavioral skills during elementary school: A within-and between-child analysis. Child development, 82(2), 601-616. https://doi.org/10.1111/j.1467-8624.2010.01533.x

McVey, G. L., Lieberman, M., Voorberg, N., Wardrope, D., & Blackmore, E. (2003). School-based peer support groups: A new approach to the prevention of disordered eating. Eating Disorders, 11(3), 169-185. https://doi.org/10.1080/10640260390218297

Mitchison D and Hay P J. (2014). The epidemiology of eating disorders: genetic, environmental, and societal factors. Clinical Epidemiology, 2014(6)89-97. doi: 10.2147/CLEP.S40841

Mond, Jonathan M. (2014). Eating disorders "mental health literacy": An introduction. Journal of Mental Health (Abingdon, England), 23(2), 51-54. DOI: 10.3109/09638237.2014.889286

Mond, J. M., Hay, P. J., Rodgers, B., & Owen, C. (2007). Health service utilization for eating disorders: Findings from a community-based study. International Journal of Eating Disorders, 40(5), 399-408.DOI 10.1002/eat

Muscat, Rebecca. (2017). Helping or Hindering? : The Professional's Perspective on Recovery from an Eating Disorder. [Unpublished Bachelors dissertation, University of Malta]. https://www.um.edu.mt/library/oar/handle/123456789/31598

Martin, J., R. & Alison Okada Wollitzer A. (1988). The Prevalence, Secrecy, and Psychology of Purging in a Family Practice Setting. International Journal of Eating Disorders 7.4 (1988): 515-19. Web. https://doi.org/10.1002/1098-108X(198807)7:4%3C515::AID-EAT2260070409%3E3.0.CO;2-R

Martinsen, M., Sherman, R. T., Thompson, R. A., & Sundgot-Borgen, J. (2015). Coaches' knowledge and management of eating disorders: a randomized controlled trial. Med Sci Sports Exerc, 47(5), 1070-8. DOI: 10.1249/MSS.0000000000000489

Mercer, Danae. [@danaemercer] (n.d.) [Instagram Profile]. Retreived June 8, 2021 from https://instagram.com/danaemercer

Mercieca, K. (2011).The Awareness of Eating Disorders amongst Girls in Secondary Schools : The Role of P.E. Teachers. [Unpublished Bachelor's dissertation, University of Malta]. https://www.um.edu.mt/library/oar/handle/123456789/4035

Micallef, L. (2003). Young Adolescents and Eating Disorders : The Level of Awareness on Eating Disorders in Maltese Secondary Schools (Bachelor dissertation, University of Malta).https://www.um.edu.mt/library/oar/bitstream/123456789/69690/1/Micallef_Lourdes_2003.pdf

Min, J., Silverstein, M., & Lendon, J. P. (2012). Intergenerational transmission of values over the family life course. Advances in Life Course Research, 17(3), 112-120. https://doi.org/10.1016/j.alcr.2012.05.001

Nowicka, Paulina, Eli, Karin, Ng, Janet, Apitzsch, Erwin, and Sundgot-Borgen, Jorunn. (2013). Moving from Knowledge to Action: A Qualitative Study of Elite Coaches' Capacity for Early Intervention in Cases of Eating Disorders. International Journal of Sports Science & Coaching 8.2: 343-55. https://nih.brage.unit.no/nih-xmlui/bitstream/handle/11250/195363/SundgotBorgen2013.pdf?sequence=1

Orsini, G. (2017). "Hunger Hurts, but Starving Works". The Moral Conversion to Eating Disorders. Culture, Medicine and Psychiatry, 41(1), 111-141. https://www.um.edu.mt/library/oar/handle/123456789/86928

Piat, M., Pearson, A., Sabetti, J. et al. International training programs on eating disorders for professionals, caregivers, and the general public: A scoping review. J Eat Disord 3, 28 (2015). https://doi.org/10.1186/s40337-015-0066-y

Price, P., Jhangiani, R.S., Chiang I.A., Leighton D.C. & Cutter, C. (2017). Research Methods in Psychology (3rd ed.). https://opentext.wsu.edu/carriecuttler/chapter/reliability-and-validity-of-measurement/

Reid, M., Williams, S., & Hammersley, R. (2009). Managing eating disorder patients in primary care in the UK: a qualitative study. Eating disorders, 18(1), 1-9. https://doi.org/10.1080/10640260903439441

Roehrig, J. P., & McLean, C. P. (2010). A comparison of stigma toward eating disorders versus depression. International Journal of Eating Disorders, 43(7), 671-674. https://doi.org/10.1002/eat.20760

Scaglioni, S., De Cosmi, V., Ciappolino, V., Parazzini, F., Brambilla, P., & Agostoni, C. (2018). Factors influencing children's eating behaviours. Nutrients, 10(6), 706. https://www.mdpi.com/2072-6643/10/6/706

Schaumberg, K., Welch, E., Breithaupt, L., Hübel, C., Baker, J. H., Munn-Chernoff, M. A., ... & Bulik, C. M. (2017). The science behind the academy for eating disorders' nine truths about eating disorders. European Eating Disorders Review, 25(6), 432-450. https://onlinelibrary.wiley.com/doi/epdf/10.1002/erv.2553

Seah, X. Y., Tham, X. C., Kamaruzaman N. R. & Yobas P. (2018). Nurses' perception of knowledge, attitudes and reported practice towards patients with eating disorders: A concurrent mixed-methods study. Archives of Psychiatric Nursing. 32 (1): 133-151. https://doi.org/10.1016/j.apnu.2017.11.011

Selby, C. L., & Reel, J. J. (2011). A coach's guide to identifying and helping athletes with eating disorders. Journal of Sport Psychology in Action, 2(2), 100-112. https://doi.org/10.1080/21520704.2011.585701

Smith, G. (2008). Does gender influence online survey participation?: A record-linkage analysis of university faculty online survey response behavior. ERIC Document Reproduction Service No. ED 501717. https://scholarworks.sjsu.edu/cgi/viewcontent.cgi?article=1003&context=elementary_ed_pub

Stein M. (2006). Meeting the Challenges of Diagnosing Eating Disorders. Eating Disorders Review 17(5). https://eatingdisordersreview.com/meeting-the-challenges-of-diagnosing-eating-disorders/

Stoutjesdyk, D., Jevne, R. (1993). Eating disorders among high performance athletes. J Youth Adolescence 22, 271–282 https://doi.org/10.1007/BF01537792

Street, G., James, R., & Cutt, H. (2007). The relationship between organised physical recreation and mental health. Health Promotion Journal of Australia, 18(3), 236-239. https://onlinelibrary.wiley.com/doi/epdf/10.1071/HE07236

Taber, K.S. The Use of Cronbach's Alpha When Developing and Reporting Research Instruments in Science Education. Res Sci Educ 48, 1273–1296 (2018). https://doi.org/10.1007/s11165-016-9602-2

Treasure, J., Claudino, A. M., & Zucker, N. (2010). Eating disorders: 1]. The Lancet, 375(9714), 583-593. https://www-sciencedirect-com.ejournals.um.edu.mt/science/article/pii/S0140673609617487?via%3Dihub

van Son, G. E., van Hoeken, D., van Furth, E. F., Donker, G. A., & Hoek, H. W. (2010). Course and outcome of eating disorders in a primary care-based cohort. International Journal of Eating Disorders, 43(2), 130-138. https://doi.org/10.1002/eat.20676

Vaughan, J. L., King, K. A., & Cottrell, R. R. (2004). Collegiate athletic trainers' confidence in helping female athletes with eating disorders. Journal of athletic training, 39(1), 71. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC385264/

Waller, G., Micali, N., & James, A. (2014). General Practitioners are poor at identifying the eating disorders. Advances in Eating Disorders: Theory, Research and Practice, 2(2), 146-157. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4047629/

Worsfold, Kate A, and Sheffield, Jeanie K. (2021). Practitioner Eating Disorder Detection: The Influence of Health Mindset, Thin-ideal Internalization, Orthorexia and Gender Role. Early Intervention in Psychiatry 15.2: 296-305. DOI: 10.1111/eip.12940

Worsfold, K. A., & Sheffield, J. K. (2019). The perceived knowledge, skill and clinical practice of psychologists, naturopaths and fitness instructors when working with eating disorders. Early intervention in psychiatry, 13(5), 1263-1270. https://doi.org/10.1111/eip.12764

Worsfold, K. A., & Sheffield, J. K. (2018). Eating disorder mental health literacy: What do psychologists, naturopaths, and fitness instructors know?. Eating disorders, 26(3), 229-247. DOI: 10.1080/10640266.2017.1397420

Yaşaroğlu, C. (2016). Cooperation and Importance of School and Family on Values Education. European Journal of Multidisciplinary Studies, 1(2), 66–71. https://doi.org/10.26417/ejms.v1i2.p66-71

Zhang, M., & Wing, T. (2015). Eating disorders. InnovAiT, 8(11), 685-691. DOI: 10.1177/1755738015594475

Appendix

Appendix A

Questionnaire

ED Knowledge Among Professionals Questionnaire

Dear Participant,
You are kindly invited to take part in our research project, which is being carried out by the Faculty for Social Wellbeing at the University of Malta. Your participation will help us to better understand the state of knowledge of eating disorders among professionals. Acceptance to participate in this study implies that you:
Are 18 years old or older; Are participating in an online questionnaire of approximately 10 minutes to share your views as a professional and/or expert working in a pertinent field; Understand that your participation is completely voluntary and that you may choose to withdraw at any time while completing the questionnaire. However, once the questionnaire is completed you will no longer be able to withdraw your participation. All responses will remain anonymous. No identifying details (namely, your name, email or IP address) will be noted, and thus, neither you or your responses can be identified. Additionally, no one will know whether or not you participated in this study.

You can save and keep a copy of this information by right clicking on the current web page, selecting 'Print' and then selecting PDF. If you have any questions about this research study, please contact [name provided] at [email provided].

By completing the questionnaire, you agree that you: (a) have read the above information, (b) voluntarily participate in this study, (c) are at least 18 years of age.

Replies are being accepted until Friday 10th.

By clicking submit, you agree to participate in this study.

Your participation is highly appreciated.

Questionnaire consent:
*
Mark only one oval.
I agree to participate (*Skip to question 2)*
I do not agree to participate (Continue to End)

Section 1: General Information
1. What is your gender
Mark only one oval.
Male
Female
Other

2. What is your age?
Mark only one oval.
under 25
25-30
31-40
41-50
51-60
over 60

3. What area/field do you work in? (E.g., teacher, GP, nutritionist, dentists etc..)
Open Response

4. How long have you been practicing?
Mark only one oval.
Less than 5 years
5- 9 years
10-14 years
15-20 years
Over 20 years

5. What locality do you practice in (if you are active in more than one locality,please select locality where you practice most frequently).
Mark only one oval.

Gozo and Comino Region	
Norther Harbour Region	Birkirkara; Gżira; Ħal Qormi; Ħamrun; Msida; Pembroke;San Ġwann; Santa Venera; St Julian's; Swieqi; Ta' Xbiex; Tal-Pietà; Tas-Sliema.
Southern Harbour Region	Cospicua; Fgura; Floriana; Ħal Luqa; Ħaż-Żabbar; Kalkara;Marsa; Paola; Santa Luċija; Senglea; Ħal Tarxien; Valletta; Vittoriosa; Xgħajra.
South Eastern Region	Birżebbuġa; Gudja; Ħal Għaxaq; Ħal Kirkop; Ħal Safi;Marsaskala; Marsaxlokk; Mqabba; Qrendi; Żejtun; Żurrieq.
Western Region	Ħad-Dingli; Ħal Balzan; Ħal Lija; Ħ'Attard; Ħaż-Żebbuġ; Iklin; Mdina;Mtarfa; Rabat; Siġġiewi.
Northern Region	Ħal Għargħur; Mellieħa; Mġarr; Mosta; Naxxar; St Paul's Bay.

Section 2: Knowledge of Eating Disorders
Please reply to the following questions by ticking True, False or Don't know:

1. Anorexia Nervosa (AN)
Mark only one oval per row.

AN is associated with extremely low BMI. People with AN have an extreme fear of getting fat. People with AN do not like to eat. People with AN may exercise excessively. You can tell if someone has AN just by looking at them People with AN know that they are too thin. People with AN have ritualistic/unusual behaviours around food. Men are not prone to AN.	True, False, Don't know

2. Bulimia Nervosa (BN)
Mark only one oval per row.

People with BN tend to lose control while eating and eat a lot of food in a short time. BN is the same as AN but with purging behaviours. People with BN tend to be underweight.	True, False, Don't know

The only way people with BN get rid of unwanted calories is by vomiting. People with BN can stop their behaviours at any time. People with BN fear gaining weight. People with BN have an urge to isolate themselves from others. Although uncomfortable, BN does not cause any actual harm.	

3. Binge Eating Disorder (BED)
Mark only one oval per row.

Binge eating is the same as over eating. People with BED have recurring and uncontrollable episodes of binge eating. If sufferers go on a diet, they can be cured People with BED eat even if not hungry. People with BED do not have will power. People with BED experience distress and shame about their binge eating. People with BED do not use compensatory behaviours for their binge eating. People with BED experience loss of control over their eating.	True, False, Don't know

4. Avoidant/Restrictive Food Intake Disorder (ARFID) (also known as SelectiveEating Disorder)
Mark only one oval per row.

ARFID is characterised by significant weight loss not related to dieting. ARFID only occurs in children ARFID can lead to significant nutritional deficiencies. People with ARFID are concerned about weight gain. People with ARFID often need nutritional supplements or enteral feeding. ARFID is the same as picky eating. People with ARFID will grow out of it. ARFID causes considerable distress to sufferers and can lead them to socially isolate.	True, False, Don't know

5. General ED Knowledge
Mark only one oval per row.

Only Anorexia is a serious eating disorder. EDs are a psychological disorder not a choice. Eating disorders are extreme diets - once the person stops dieting, they will get better. EDs have the highest mortality rate of any mental illness. Eating disorders are caused by bad parenting. EDs are often about emotions not food. It is impossible to cure eating disorders. Purging only involves self-induced vomiting.	True, False, Don't know

Section 3: Experience and Attitudes to EDs
Please tick Yes, No or Not Applicable for the following:

Mark only one oval per row.

In your practice/professional encounters, do you ever ask clients about eating habits?	Yes, No, Not Applicable
Have you ever had a client with an eating disorder?	
Did you speak to the client or parents (for under age children) to refer them onwards?	
In your practice/professional encounters, do you ever enquire further about any physical symptoms – e.g. absence of periods, reasons for and length of bleeding gums, etc?	
Do you screen for EDs in your profession?	
If you answered no to the above – do you think that you should include questions about eating habits in your line of work?	
Do you think there might be cases of discrimination towards people who are overweight in your profession?	
Do you feel that you need more information or training about eating disorders?	

Section 3 (cont.) : Experience and Attitudes to EDs
For the following please select the answer that best reflects your opinion:

How do you consider EDs in Malta? (Tick the one you believe is most appropriate).
Mark only one oval.
A major problem
A moderate problem
A minor problem

Do you think EDs affect Males:
Mark only one oval.
A lot
Somewhat
Not much
Not at all

How difficult did/would you find it to inform the client/parents if you felt they had an ED?
Mark only one oval.
Difficult
Moderately difficult
Not difficult

Where would you prefer an ED service to be delivered: Please rank the suggestions below in order of preference:

Mark only one oval per row.
Hospital Local Council Pharmacy Health Centre
1st Choice, 2nd Choice , 3rd Choice, 4th Choice

Thank you for your participation!

Appendix B

Text of Email to Gatekeepers

Text email to gatekeepers:

Dear [Gatekeeper],

I would like to introduce myself. I am a Research Officer with the Faculty for Social Wellbeing. Research conducted last year by the Faculty for Social Wellbeing in collaboration with Dar Kenn għal Saħħtek has revealed that eating disorders are on the rise, especially among young people. The sooner a person is diagnosed and receives treatment, the better their chances of recovery. The Faculty for Social Wellbeing at the University of Malta is investigating the current state of knowledge of eating disorders among professionals. These may be first-in-line-of-contact for persons with eating disorders and couldhelp stir the person in the direction of diagnosis and treatment.

We would like to ask you to disseminate the attached questionnaire to your members. As experts in their fields, we wish to invite them to participate in this online questionnaire, which should take about 10 minutes to complete.

Participation is entirely voluntary and, in line with General Data Protection Regulations (GDPR), while completing the questionnaire, participants have the right to information, access, rectification, objection, erasure, data portability and consent withdrawal. However, as this is an anonymous questionnaire and respondents' details are not collected, once the response is submitted, there will no longer be an opportunity for rectification or withdrawal. Data collected will be completely anonymous and no personal identifiers (name, email or IP address), will be collected. Participants should be 18 years or older.

Participants will not receive any direct benefits from participating in this study, however, their responses will help us gain an in-depth understanding of the knowledge of eating disorders among professionals, identify gaps, and will assist in planning any necessary courses or information sessions.

To this end I would be grateful if you could reply by email to let me know that you are happy to disseminate this questionnaire, and that you will forward it to the members of your association.

If you have any questions please do not hesitate to contact me.

Kind regards

[signature etc]

Appendix C

Project title: ***Examining the Experience of First-Contact Professionals in Dealing with and Diagnosing Eating Disorders***

You are kindly invited to take part in our research project, which is being carried out by the Faculty for Social Wellbeing at the University of Malta on behalf of Dar Kenn għal Saħħtek.

Professionals such as educators, doctors, psychologists, dentists, gastroenterologists, counsellors and others are excellently placed to recognise if a person they encounter professionally presents with symptoms that could indicate the presence of an Eating Disorder. This study will examine the state of knowledge of Eating Disorders among Professionals or other potential persons who may be in first-line-of-contact positions. The aim of this project is to identify whether there is a need for the dissemination of information or training among professionals, and provide policy and action recommendations. Your participation will help us understand the current state of knowledge of professionals, examine any gaps and seek to understand potential information needs. Any data collected from this research will be used solely for the purposes of the study. If you choose to participate, please note that there are no direct benefits to you from your participation, but that your contribution will help to plan future policy and interventions.

Participation in this study is entirely voluntary, you are free to accept or refuse to participate without needing to give a reason of your choice. Your participation does not entail any known or anticipated risks. Should you choose to participate, you will be invited to take part in an online focus group of approximately two hours, that can be held at a convenient time. An audio recording of the discussion will be made to allow for later data analysis. Your name and surname and any other personally identifiable details will not be used in the study or disseminated in any way, guaranteeing anonymity.

In accordance with the General Data Protection Regulations (GDPR), you have the right to information, access, rectification, objection, erasure, data portability, and to withdraw your consent at any time during the study, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw your participation, any data collected from you will be deleted.

Data collected from the focus group will be used solely for the purposes of this study and will be stored securely and separately from the consent forms and any other personal information. Additionally, the data collected will be pseudonymised and encrypted to ensure that it is stored safely and in a way that guarantees your anonymity, and only the research team will have access to the raw data collected from the focus group. Raw data from the study will be erased one year from the completion of the study.

A copy of this information sheet is hereby being provided for you to keep and for future reference.

I would be grateful if you would respond to this email if you would like to participate in an online focus group. If you have any questions or considerations, please do not hesitate to contact me by email on [email provided]

Your contribution is of great value to this study. Whilst thanking you in advance, we look forward to your participation.

Sincerely,

Research Support Officer II
Faculty for Social Wellbeing

Appendix D

Consent Letter for Focus Groups

Consent Form – Focus Group

Project title: Examining the Experience of First-Contact Professionals in Dealing with and Diagnosing Eating Disorders

Research Team & Contact Details:

Project Leader [Name and email provided]

Research Officer [Name and email provided]

Eating Disorders are dangerous psychological and eating disturbances. Research shows that the sooner they are diagnosed, the better the outcome for the sufferer. The Faculty for Social Wellbeing at the University of Malta on behalf of Dar Kenn għal Saħħtek, is exploring the state of knowledge of eating disorders among professionals who may be first-in-line-of-contact for persons with eating disorders and may help stir the person in the direction of diagnosis and treatment. The aim of this project is to identify if there is any need for the dissemination of information or to deliver training, and provide policy and action recommendations.

Acceptance to participation in this study implies that, as a research participant, I:

1. I have been given written and/or verbal information about the purpose of the study; I have had the opportunity to ask questions and any questions that I had were answered fully and to my satisfaction.
2. I understand that I am free to accept or refuse to participate, or stop participation at any time without giving any reason and without any penalty. Should I choose to participate, I may choose to decline to answer any questions asked. In the event that I choose to withdraw from the study, any data collected from me will be erased.
3. I understand that I have been invited to participate in a one-time, online focus group of approximately two hours. I understand that the focus group will take place at a time and via a platform that is convenient to the group.
4. I understand that my participation does not entail any known or anticipated risks. I also understand that there are no direct benefits to me from participating in this study, but that this research may benefit others as the results of the study will aim to improve professional knowledge of Eating Disorders, inform policy recommendations and serve to improve the services provided.
5. I understand that, under the General Data Protection Regulation (GDPR) and national legislation, I have the right to access, rectify, and where applicable, ask for the data concerning me to be erased.
6. I am aware that if I give my consent, this focus group will be recorded and converted to text as it has been recorded (transcribed), and that extracts of the discussion may be reproduced in the study outputs in a pseudonymised form.
7. I am aware that focus group discussions should be considered confidential and that I should not disclose details of those participating and/or of the nature of discussions to others.
8. I understand that all data collected will be stored in an anonymised form, and that the raw data will be erased one year from completion of the study.
9. I have been provided with the study information and will be given a copy of this consent form, which includes the contact details of the researcher.

I have read and understood the above statements and consent to participate in this study.

Participant name and surname: _____

Signature: _____

Date: _____

Researcher Name: _____

Researcher email address: _____

Thank you for your participation.

Appendix E

Question Guide for Focus Groups

Eating Disorders and Professionals – Question Guide for Focus Group:

1.	Could you tell me a little about yourself and your work?
2.	What services do you provide?
3.	Do you think that eating disorders are a concern in your area of practice
4.	Do you think that professionals in your field are able to recognize EDs in their professional encounters?
5.	How would you go about speaking to clients about a potential eating disorder?
6.	What do you think are the challenges/dangers of this?
7.	Do you think that you would require further information?
8.	Would you follow a course/seminar/once or twice-yearly session? Would you be willing to pay for this?
9.	Is there anything else you would like to add?